

Deconstructing Evidence-Based Practice and its Application to Children with
Mental Health Disorders

Sue Etherington, Master of Arts

Child and Youth Studies

Submitted in partial fulfillment
of the requirements for the degree of

Master of Arts in Child and Youth Studies

Faculty of Social Sciences, Brock University
St. Catharines, Ontario

© 2013

Abstract

This is a mixed methodology study that uses an autoethnographic approach to combine both an autobiography and a survey of practitioners who work in children's mental health. It is largely about the implementation of Evidence-Based Practice (EBP), and the questions, concerns, experiences that I have had, and compared them with those of my fellow practitioners. In addition, it is about my journey as a mental health professional, and how I have come to recognize that in order to achieve the goals I wanted to achieve, I needed to return to university to pursue a Master's degree. Within the research, I identify and discuss different definitions of EBP and identify several themes. I deconstruct the implementation of EBPs through the lens of Foucault and his notions of governmentality. I offer policy and practice recommendations to improve the implementation of EBP and the services received by children facing mental health issues.

Acknowledgements

I wish to thank first and foremost, my husband, Dave, for his tremendous, unwavering support throughout this entire process. He is my rock and never complained, questioned, argued or expressed disappointment or frustration with the lost days that we could not enjoy together because of my need to work on this thesis. I would also like to thank my family and friends for supporting me and offering words of encouragement and asking questions and being interested even though they may not have had the faintest idea what I was talking about.

I would also like to thank my advisor, Dr. Dawn Zinga, who, several months ago, offered me words that I have held onto when times were very difficult. "If it was easy, everyone would do it." When I was having difficulty seeing the next step, a meeting with her would put everything in perspective. I would also like to thank my committee members, Dr. Fran Owen and Dr. Kathy Skott-Myhre, for their support and feedback, and honesty throughout this project. A special thank you to Dr. Hans Skott-Myhre for his incredible insight into and translation of Foucault. A heartfelt thank you to the wonderful young women that were my classmates while pursuing my Master's degree – an inspiration then and now... "the world is your oyster."

Lastly, but certainly not least, I would like to thank the agency for which I work, the people of whom were incredibly supportive and giving of time, encouragement, feedback and humour, all of which contributed to allowing me to persevere and finish this project.

Table of Contents

Acknowledgements

Table of Contents

List of Tables and Figures

Chapter 1: Introduction.....	1
Chapter 2: Literature Review.....	6
Defining EBP.....	7
Evidence.....	13
Social Work and EBP.....	16
Implementing EBP in Social Work.....	22
Co-Morbidity.....	25
EBP as a Process.....	30
Chapter 3: Theoretical Framework and Methodology.....	35
Methodology.....	44
Autoethnography: Rationale.....	45
Survey.....	48
Chapter 4: Autobiography.....	50
Chapter 5: Survey Results.....	78
Chapter 6: Autoethnography.....	92
Themes.....	92
Education, Experience and Respect.....	92
The Implementation of EBP.....	99
Value of Relationships.....	112

Need for Training.....	115
The Elephants in the Room.....	118
Chapter 7: Conclusion.....	123
References.....	133
Appendix I.....	145

List of Tables and Figures

Tables

Table 2.1. Rating System for Hierarchy of Evidence.....	16
Table 5.1 Correlational Table Illustrating Pearson Correlation, Significance and Total Number of Responses.....	80
Table 5.2. Significant Correlations.....	81
Table 5.3 Survey Score Mean by Years Worked.....	87

Figures

Figure 2.1. Akobeng's (2005) Hierarchy of Evidence.....	15
Figure 5.1 . Correlational diagram of participants who feel equipped to use EBPs and associated correlations.....	90
Figure 5.2 Correlational diagram of participants exhibiting worries of being “caught” not using EBPs and associated correlations.....	91

Chapter 1: Introduction

I have been working in children's mental health for almost twenty-five years, in varying capacities: as a counsellor, therapist, and family worker, among other roles. During my tenure, I slowly came to the conclusion that I needed to pursue a Master's degree in this field in order to do what I enjoy the most – provide in-patient family and individual therapy in a full-time capacity. In the process of achieving this goal of a higher education, I struggled with an area to concentrate on in terms of research, eventually deciding on exploring a better understanding of the movement towards Evidence-Based Practice (EBP) in children's mental health. I have wrestled with the implementation of such interventions, and noticed that in my experience with other professions there has not been a great deal of dialogue as to what it all entailed. The expectation has been that mental health practitioners would just start to use EBPs with very little training. While some of my fellow mental health practitioners seemed better versed in EBPs than others, I felt intimidated and thus shied away from asking questions. I was afraid that I was not doing what I was being paid to do, and afraid that I was going to get 'caught' at this. In thinking about the topic more closely, I began to think that I might not be alone in my confusion. If I felt this way, surely there were others who felt similarly. Thus, I decided to complete an autobiography exploring my experiences, and to assess (via surveys) whether fellow practitioners in children's mental health were experiencing the same dissonance.

My autobiography is about my journey in the pursuit of having a better understanding of myself, and what I have experienced on a personal as well as a professional level. It has been just that: a journey. I have found many parallels in my journey pursuing my Master's degree and my exploration of the implementation of EBP in children's mental health. In many ways the two are entwined as, within the last ten years, there has been a decided push to implement EBP in

children's mental health that has coincided with the movement towards more standardized levels of education for those people who work in government-funded children's mental health agencies. This is not likely coincidental as both of these movements speak of ensuring that there is some accountability for service provision on two different levels. The government that funds public agencies wants guarantees that treatment is empirically supported, and that those who deliver it are substantially trained. To take this one level further, there is a current push for professionals to be registered in the College of Social Workers (www.ocswssw.org) so that those who work in this field are held to a certain standard of practice. Registration with a professional regulating body allows for closer supervision of the performance of those who are being paid out of the public's purse. There has, however, been some immediate resistance to this, as professionals do not necessarily agree to enroll in what some consider to be a pretentious governing body to whom professionals are required to pay fees. Despite the pushback, it is likely that this will be a requirement in the not-so-distant future.

My decision to pursue a Master's degree satisfies requirements that are necessary for both the agency I work for, as well as those of other Ministry of Child and Youth funded agencies. This increasing need for higher educational qualifications has parallels with the implementation of EBP. Both are stipulations and both demonstrate movement away from social work being identified as an art to that of being defined as a science, and this is further supported by the assertion that therapists should have a Master's degree. I invite others to share my journey as I describe how I came to take such a step in my career by pursuing a Master's degree. I started out with the raw emotions that I have experienced during my journey and my determination to take a vulnerable stance in exploring my own thoughts and feelings, and putting them on paper. I believe I have grown tremendously as a result of being able to do so. In addition, I have taken

those raw emotions and my openness and used them as the catalyst to explore EBP and consider how it is being implemented and where open discussions about its implementation may improve service provision. By opening up myself to others, I am offering insight as to what being a therapist means and how the movement to EBPs can be perceived as important. There are some limitations to the use of EBPs, however, and while they can be viewed as providing empirically-validated guidelines for helping people, there needs to be some ability to be flexible in their implementation.

Throughout my exploration of EBP, I also discuss how relationships have appeared to take a backseat in the client-therapist dyad in recent years. This seems to be the result of the concept of the therapeutic alliance being diminished, while the scientific aspect is being highlighted. I believe that the relationship between therapist and client should never be taken lightly nor replaced by a simple manual that can be administered by anyone, regardless of qualifications or personality. I have found that others share my belief as well. The concern, however, is that this will be the outcome of the shift towards EBP. By discussing this more openly, there is the opportunity for practitioners to recognize that there is still a need for their relationship with their clients to be emphasized. I hope that by giving voice to the thoughts and beliefs of my colleagues, their opinions will be taken seriously as well. In any workplace, exploring and articulating one's own individual experiences can be uncomfortable. I feel sad that there is a discomfort with this and I hope that by discussing such a controversial topic within my Master's thesis, barriers will be torn down so that these types of discussions can occur in staff meetings and supervisions, freely, without fear of reprisal.

I argue that the experiences and reflections of myself and of fellow practitioners can provide important insights at a government level, in terms of how the implementation of EBP

impacts funding strategies and treatment delivery. The various ministries need to take a hard look at how they fund agencies and the associated implications for treatment. This close examination of the links between policy, implementation, and practice will help ensure that children in need get the support that is essential so that they do not fall between the cracks. It is vital that the help that is received is not limited to the three or six sessions that the manuals recommend. I am opening myself up so that others will see my willingness to become vulnerable to ridicule or scrutiny as a way to allow themselves to embrace this kind of vulnerability as well, as I believe it is how we get better at what we do.

In my first chapter, I present a review of the literature on EBP. The second chapter discusses the theoretical framework in terms of Foucault and his notions of governmentality, in relation to the movement of EBP in children's mental health. This chapter also includes the methodology section, describing the survey and the participants. In chapter three, I describe my experiences in an autobiography. This is followed in chapter four, in which I present the data from the survey. An autoethnographical analysis of the literature review, my autobiography, and the survey results occurs in chapter five. The conclusion offers some recommendations for the children's mental health sector.

Determining a thesis topic was important to me, as I wanted it to be meaningful, for myself and hopefully for others as well. I could have conducted research for a professor on a topic that I may have found some interest in; however, I wanted to be able to immerse myself into something that struck a chord for me, and this was not an easy decision. Looking back, I am pleased with my decision to pursue this more personal and reflective path. My hope is that the reader will better understand my journey both academically, and how I got to the point that I believed that exploring these topics was worth researching.

There is a great deal of literature on EBPs in many different fields. It began with the medical field and has moved into dentistry, addictions, nursing, mental health, and beyond. While it is a movement that is here to stay, much of the research has been mixed in terms of the support that it has found in the many different areas. Some research findings provide empirical support for the implementation of EBPs, while others offer counter conclusions – and there is much variance in between these two extreme positions. The movement of experimentation from the lab to the clinical setting has caused a great deal of debate, in that some people argue that it is plausible, and others believe that it is too much of a reach. The effort to define what evidence is remains a subject of controversy. Because the phrase EBP often is confused with and believed to be a manualized treatment, I will focus on the provision of those interventions that are manualized. As such, when I am discussing EBP throughout my thesis, what I am referring to is manualized treatment.

I administered a 20-item self-report survey to other practitioners in a children's mental health agency, to determine their level of understanding and support of EBPs in their experience. This was not meant to be a policing act, and I had hoped that I had made that clear in my invitation to participate. As I feared, however, some people seemed to interpret it as such and refused to partake in the survey. There was a great deal of information that was derived from both the completed surveys and those that were not completed. There were many similarities between my own reflections of EBP and those of my colleagues in the responses to the survey. Much of this was supported within the literature. Several themes emerged from my autobiography and the survey. Some themes were not surprising at all, while others caught me off guard. As a result, I offer an analysis of these themes as well as implications for future research and future movement in the field of children's mental health.

Chapter 2: Literature Review

In this chapter, I will explore the concept of EBP, with a particular focus on how it applies to children with mental health diagnoses. EBP is the mode of service delivery that receives the majority of funding from mental health governing parties in the United States and Canada (Barwick, Boydell, Stasiulis, Ferguson, Blase, and Fixsen, 2005). There are many types of EBPs in existence, which are supported by empirical evidence regarding their effectiveness. Treating a child with anxiety disorder with the Coping Cat program (Albano & Kendall, 2002) should result in decreased anxiety and anxiety-related behaviours. Parents can be taught 1-2-3 Magic (Phelan, 2004) which will result in more effective parenting strategies. Treating a child who has conduct-disorder with SNAP (Koegl, Augimeri, Ferrante, Walsh & Slater, 2008) will decrease the probability of later imprisonment, based on the specific symptoms that these programs are intended to decrease.

Such tools are valuable, and I believe every effective practitioner needs to have an understanding of these strategies in order to function professionally. I also argue however, that there are other aspects that need to be taken into account. This is the area that many practitioners have been struggling with for the past ten or so years in that it appears that suddenly, what was being conducted in therapy was no longer deemed effective (Schon, 1983; Gambrill, 2006). Research has demonstrated that approaches supported by EBP are effective in treating a specific concern or set of concerns such as anxiety or conduct disorder. However, much less research has focused on how such approaches apply to those individuals who have more than one identified diagnosis. What interests me is how EBP is understood by front-line staff and its efficacy for children who have more than one diagnosis.

Throughout this literature review, I will focus on many different aspects of EBP. The definition of EBP, as well as the definitions of Evidence-Based Treatment (EBT) and Evidence-Informed Practice (EIP) will also be discussed. The range of what is determined to be evidence will be explored from a very rigorous viewpoint, such as the Cochrane Collaboration (Cochrane, 1972) to a less stringent characterization of what evidence is, in terms of seeing progress and a decrease in symptomology. The application of EBP in Social Work will also be examined, as well as the struggles that have developed as a result of some of the push for EBPs to be implemented.

Defining EBP

There is a great deal of literature that discusses EBP. Some individuals are supportive of the thrust towards its use in children's mental health (Gibbs & Gambrill, 2002; Howard, McMillen, & Pollio, 2003; Blom, 2009), others are not (Webb, 2001; Gray & McDonald, 2006; Van De Luigaarden, 2009). In addition, there are many different interpretations of the definition of EBP, and how EBP is promoted and utilized in the children's mental health sector. EBP is based on a medical model, and was developed out of the concern that medical practices were not being supported by research (Cochrane, 1972; Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996; Mills, Montori, & Guyatt, 2004). Attention is now being given to measureable outcomes, that support the necessity of cost-effective delivery of services. Social workers are now being asked to provide the same accountability for their work with clients; measuring the outcomes and using interventions that have been proven to work for a given diagnosis. Because it comes from the medical model, EBP was initially defined as "the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients" (Sackett, 1997, p. 3). Other definitions have been bandied about; including a more in-depth inclusion of the use

of randomized controlled trials (RCTs) in determining what can be classified as an EBP. The Oregon Office of Mental Health and Addiction Services operationally define EBP in terms of RCTs being at the top of the evidence based scale and implementation of such must be measured by a fidelity tool (State of Oregon, 2003). Research in Oregon must also include the relative financial cost in its definition of effective treatment. Drake et al. (2001) characterize EBP as interventions “for which there is consistent scientific evidence showing they improve client outcomes” (p. 180), a definition which takes a broader approach. Waddell and Godderis (2005) loosely define EBP in terms of health care professionals implementing the best and most current available research evidence when providing service.

The American Psychological Association (2005) describes EBP in psychology as “the integration of the best available research with clinical expertise in the context of patient characteristics, culture and preferences.” (p. 19). In the substance abuse sector, policy makers have avoided using an operational definition of EBP because “there is no consensus on what exactly constitutes an EBP” (Iowa PIC Project, 2003, p. 4) choosing instead to rely on a set of 13 criteria to determine how it is to be implemented into practice. This model admittedly has limitations that were identified. To allow individual states or townships to make modifications, the model allowed room for interpretation and was purposefully not precise.(Iowa PIC Project, 2003). The Iowa PIC Project (2003) has outlined these thirteen criteria of how EBP is put into practice as follows:

1. At least one randomized clinical trial has shown this practice to be effective.
2. The practice has demonstrated effectiveness in several replicated research studies using different samples, at least one of which is comparable to the treatment population of our region or agency.
3. The practice either targets behaviors or shows good effect on behaviors that are generally accepted outcomes.
4. The practice can logistically be applied in our region, in rural and low population density areas.

5. The practice is feasible: It can be used in group format, is attractive to third party payers, is of low cost, and training is available.
6. The practice is manualized or sufficiently operationalized for staff use. Its key components are clearly laid out.
7. The practice is well accepted by providers and clients.
8. The practice is based on a clear and well-articulated theory.
9. The practice has associated methods of ensuring fidelity.
10. The practice can be evaluated.
11. The practice shows good retention rates for clients.
12. The practice addresses cultural diversity and different populations.
13. The practice can be used by staff with a wide diversity of backgrounds and training (Iowa Pic Project, 2003, p. 4-8).

In looking at EBP in children's mental health in Ontario, Sackett et al.'s (1997) definition is also utilized in terms of setting the parameters of EBPs. Children's Mental Health Ontario (CHMO) however takes a more in-depth approach to the global service delivery of EBPs, and clearly distinguishes EBP from EBT. This distinction is important but does not appear to be commonplace. In children's mental health services, therefore, "the term EBP refers to a body of scientific knowledge about service practices, including referral, assessment, outcome management/assessment, quality improvement practices, and case management" (Hoagwood, Burns, Kiser, Ringeisen, & Schoenwald, 2001, p. 7). EBP also refers to scientific knowledge as to the impact that certain treatment applications have on the mental health of those individuals under the age of 18. EBTs are specifically the interventions that are empirically supported. EBT refers to those treatment modalities which have been proven to be empirically sound, having been subjected to at least two randomized controlled trials, with a minimum of 30 participants of the same age group receiving the same treatment for the same target problem (Hoagwood et al., 2001). The majority of subsequent studies must support the treatment, and acceptable adherence to the new EBT manual must occur (Hoagwood et al., 2001). With this being so clearly defined in terms of Children's Mental Health in Ontario, it is curious that there remains such confusion

and the terms often become interchangeable. It is no wonder that the term EBP is often scoffed at, misinterpreted, and misunderstood in front-line work.

Kazdin (1999) has described four areas which serve as criteria for assessing an evidence base: (1) a theory to relate a possible intervention to a diagnosis; (2) research to determine the validity of the intervention; (3) primary outcome evidence to show that the intervention changes the outcome; and (4) connections between intervention and outcome which show that there is a relationship between the two. Kazdin, therefore, has shown a process for finding a valid method for evaluating the impact that an intervention has had on a client.

Gibbs and Gambrill (2002) also suggested a process for the development of EBP, which consists of six steps: (1) restricting assessment information to specific questions that can be answered empirically; (2) completing a literature review; (3) evaluating the quality and usefulness of the literature; (4) considering the unique needs and wishes of the client; (5) delivering the evidence-informed intervention; and (6) measuring and evaluating the outcome. According to this approach, the term EBP can be viewed as a journey or a process in itself, as opposed to developing a manualized intervention, and researching this to determine if it works for all persons who have the same diagnosis. Gigun (2005) has a similar understanding in which he believes that EBP in social work is based on four cornerstones: (1) research and theory; (2) what we and others have learned from our clients (including professional values); (3) our own personal assumptions, values, biases, and world views; and (4) what our clients bring to the session.

In the medical field, the evidence comes from the root of quantitative analysis, rather than qualitative. In this field, the assumption is that qualitative analysis is only based on intuition, thus disqualifying any qualitative measurement as being worthy (Fevisch & Murray, 2009). With the

advancement in social work and psychology to look at qualitative data more critically, there has come to be an acceptance of utilizing experiential information in a more scientific manner.

Devisch & Murray (2009) thought that attempting to distinguish the difference between admissible evidence from inadmissible evidence is based on intuition, rather than evidence. The authors argued that it was not possible, based on the logic of EBP, there could “ ‘be no evidentiary’ basis for its distinction between admissible and inadmissible evidence” (p. 953). While this seems confusing, what the writers are indeed suggesting is that there needs to be interpretation behind what one would consider acceptable evidence and what would not be considered to be acceptable enough.

Pollio (2006) incorporates a different definition of EBP, which also takes into account qualitative methods such as narrative, focus groups, and case studies. Pollio defines EBP as the “conscientious and judicious use of best practice in making decisions for individual treatment,” (p. 224), making room for both qualitative as well as quantitative data. This puts the onus on the practitioner to be able to define what evidence was used in the decision making process. Pollio viewed this as deconstructing the evidence to determine what is best for the client, as opposed to arbitrarily selecting an intervention based on the symptoms or diagnosis.

Larner (2004) looked at the politics of EBP in family therapy and suggested that because it is language-based, client-driven, and focused on the process of relationships, attempting to mold it into an EBT is limiting to practitioners. By focussing on EBP in this type of therapy, the definition of “evidence” also comes into question. Hall (2008) concurred, asserting that categorizing his clients and their difficulties feels unnatural and by doing so, a barrier to the patient-practitioner is formed. While Hall agreed that the core values of EBP are important and a

progressive manner in which to provide treatment, he also believed that linking the individuality of clients with research is difficult to achieve in a therapeutic setting.

Evidence Informed Practice (EIP) has been another interchangeable term along with EBP and EBT. EIP has its own definition, which is also mired in controversy and confusion. In a workbook about EIP written by Unison Health and Community Services (2010), EIP is described as an “approach to programs or service delivery in which service providers, program implementers and program planners are aware of the evidence relevant to our practice or program initiatives, and apply that knowledge within the scope of our work” (p. 7). Anderson (2007) stated that the most commonly used definition of EIP is “the integration of experience, judgement and expertise with the best available external evidence from systematic research” (p. 1). Again, a concept driven by the health field and medicine, EIP is based on the principle that the development and execution of interventions is informed by the most recent, consistent, and relevant evidence about their efficacy (Anderson, 2007).

EIP looks at defining evidence from a large pool of sources, including academic journals, statistics, systematic reviews, as well as knowledge of experienced workers (Chalmers, 2005; Anderson, 2007). The basic thrust for EIP is that service providers look to systematic reviews of research to inform their judgments in terms of the kind of intervention and treatment which they will decide to provide in a given situation. The differences among EBP, EBT, and EIP are subtle yet distinct, and in order to provide the best service delivery possible, professionals need to have a solid understanding of what these terms mean. Having a solid understanding allows the practitioner to be able to explain what intervention is being implemented with a client, and also allows the professional to recognize what is expected of them. Within these three terms, the word systematic continues to be present and perhaps,

therefore, is key in that it is the opposite of anecdotal (Rycroft-Malone & Stetler, 2004). While anecdotal experiences used to drive social work practice in the past, the professional standard is now demanding an empirical foundation.

With these definitions, as lucid or as opaque as they may be, there continues to exist a real disparity in the understanding of EBP and whether it should be viewed as a verb or a noun. In order to start to understand what exactly it is, and how it is being implemented, some valid, supported definitions need to be utilized in order to determine what direction we are moving in. A major question is whether social work can adopt such a staunch medical model without modifying this model to be more realistic when emotions and individual personalities, not to mention relationships, are first and foremost in the picture. I will next explore the definitions of evidence, and determine how these definitions fit within the context of social work practice.

Evidence

What constitutes evidence? According to Webster (www.websters-dictionary-online.org), scientific evidence is

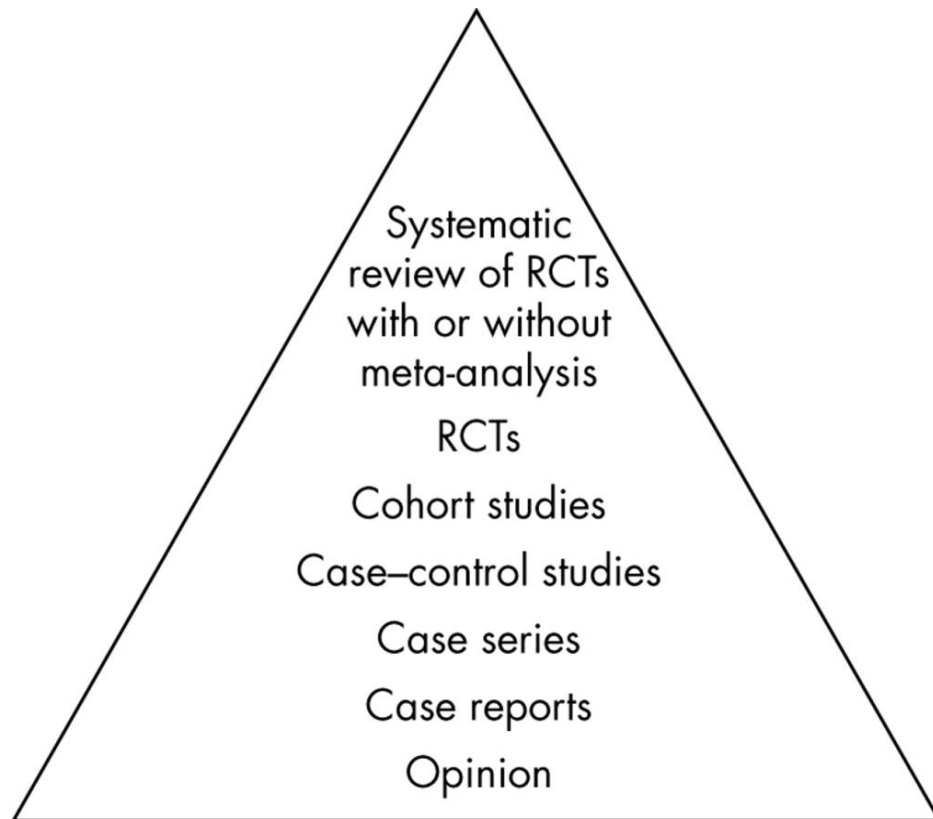
accumulated through observations of phenomena that occur in the natural world, or which are created as experiments in a laboratory. Scientific evidence usually goes towards supporting or rejecting a hypothesis. When evidence is contradictory to predicted expectations, the evidence and the ways of making it are often closely scrutinized (see experimenter's regress) and only at the end of this process the hypothesis is rejected: this can be referred to as "refutation of the hypothesis." The rules for evidence used by science are collected systematically in an attempt to avoid the bias inherent to anecdotal evidence: nonetheless even anecdotal evidence is enough to reject a theory incompatible with that evidence, if there are sufficient repeated examples.

While this definition has been accepted in terms of science, there exists a wider spectrum of the definition of evidence when it comes to EBP. Looking back to Sackett et al. (1996), evidence in medicine was defined as that practice which is patient-focussed and clinically relevant, honing in on such areas as the "...accuracy and precision of diagnostic tests, the power

of prognostic markers, and the efficacy and safety of therapeutic, rehabilitative, and preventive regimens” (p. 71). MacPhee and Pratt (2005) take the definition of evidence beyond just the collection of research, benchmark, and internal data, to include patient and family preferences as well as clinical expertise.

To assist in the evaluation of research findings, hierarchies of evidence have been developed to categorize research according to its validity. The Canadian Task Force on the Periodic Health Examination began to develop a hierarchy in 1979 and, since then, many different grading systems have been established (Evans, 2003; Akobeng, 2005; Melnyk and Fineout-Overhold, 2005). In general, these hierarchies have concentrated on effectiveness, which resulted in randomized control trials (RCTs) being viewed as the highest level of evidence. The following is an example (see Figure 2.1) of a hierarchy of evidence from the medical model, which demonstrates the different levels of efficacy (Akobeng, 2005).

Figure 2.1. Akobeng's (2005) Hierarchy of Evidence



Akobeng (2005, p.841).

Table 2.1. Rating System for Hierarchy of Evidence

Level	Description
Level I	Evidence for a systematic review or meta-analysis of all relevant RCT or evidence-based clinical practice guidelines based on systematic reviews of RCT
Level II	Evidence obtained from at least one well-designed RCT
Level III	Evidence obtained from one well-designed controlled trial without randomization
Level IV	Evidence from well-designed case-control and cohort studies
Level V	Evidence from systematic reviews of descriptive or qualitative study
Level VI	Evidence from single descriptive or qualitative study
Level VII	Evidence from the opinion of authorities and/or reports of expert committees

Melnyk and Fineout-Overhold (2005, p. 10)

RCTs have long been considered the “gold standard” for evaluating the effectiveness of interventions, whether they are medical, psychological, or social-work based (Kaptchuk, 2001; Simon, 2001; Akobeng, 2005; Grossman & Mackenzie, 2005; Cartwright, 2007;). While Melnyk and Fineout-Overhold’s (2005) system was formulated based on nursing care, there appears to be little change across the disciplines when it comes to EBP, as the crux is for finding evidence which promotes and supports scientific truth. In general, it is a quantitative approach to evidence which is being sought, whereby numbers reflect the impact of an intervention to show that there is positive change, hence the importance of RCTs.

Social Work and EBP

To take a step back, a working definition of social work must be determined. While there are a few different definitions of the term social work, there are two which are most widely accepted at this point, derived from the National Association of Social Workers (NASW) and the International Federation of Social Workers (IFSW). NASW defines Social Work as “the applied science of helping people achieve an effective level of psychosocial functioning and effecting societal changes to enhance the well-being of all people” (Barker, 2003, p. 408). The IFSW has a broader definition, “...social work bases its methodology on a systematic body of evidence-based knowledge derived from research and practice evaluation, including local and indigenous knowledge specific to its context . . .” (IFSW, 2000, p. 1).

It is interesting that much of the existing research discusses the movement of social work from an art to a science, and that social workers in general have often felt marginalized because the practice of social work has traditionally not been grounded in science. The same beliefs have also been experienced in other professional groups, such as psychology, dentistry, and to a lesser degree, medicine.

A study by Beddoe (2010) found that social workers believed they were perceived as less intelligent than other professionals in psychology and psychiatry; were conscious of their lack of confidence and therefore more prone to defend themselves by reverting to practical ideals of social work activity instead of focusing on research to back themselves up. Gambrill (2006) argued that evidence-based decision making came into being as an alternative to authority-based decision making in which treatment decisions are based on such factors as consensus, anecdotal experience, or tradition. The fear that one's livelihood is being stripped of these three important credentials can be viewed as quite threatening as well, resulting in feelings of inferiority when being pushed towards more scientific practice.

Matthew et al. (2003) found similar results to Beddoe's (2010) study, determining prior to the larger advancement towards EBP, in that social workers primarily relied on the advice of their fellow employees and direct supervisors, personal experiences, relevant theory, and authoritative texts for practice direction. All of those seemed to be enough at that point, so there has been some resistance to accept a research-based shift. It seems that social workers have felt more open to scrutiny in what they have been providing in terms of treatment up to this point, and a change to EBP can be interpreted as suggesting that what practitioners were doing prior to EBP was invalid and therefore needs to be changed. Resistance is quite futile, as EBP is a wave which is not going to go away; making that adjustment opens us all up to being vulnerable in which we are now going to be held accountable and need to use clinically proven treatments. Humphries (2003) supported this notion as well, stating that social work "has had limited success in achieving professional status through other means, and is currently pursuing a particular identity through what is presented as a scientific approach to research" (p. 85) in hopes of attaining the same status as psychologists or medical practitioners.

While there has been some resistance to the acceptance of social workers in the movement towards EBP, there has also been some embracement of it. Blom (2009) found that many social workers argue that evidence-based knowledge is less useful than their own experiences or those of colleagues when it involves people's individual experiences. He suggested that the practice of social work requires different kinds of knowledge, not only that which is evidence-based. Blom then went on to argue that social work is a science which deals with social and psychological issues that are much more unpredictable than other natural sciences, and thus, social workers need to be open minded, and not just rely on theory and models.

Many would agree with Blom (2009) in his statement that treatment for our clients begins with the relationship between the client and the social worker. It leaves one wondering about the impact that using EBP will have on this relationship, or perhaps more realistically, the perceived impact that utilizing EBPs will have on relationships. In a New Zealand study of the movement of social work towards EBP, Beddoe (2010) found that front-line staff as well as managers resist applying manualized treatment to a person who is struggling significantly. One practitioner expressed that while EBP is valuable, many other therapeutic approaches are not viewed as measurable, as of yet. Thus, while some interventions fit well within a scientific model, and as such are often viewed as ‘best practice,’ other interventions which are more challenging to measure may be more helpful, but have not been scientifically validated. Another participant in Beddoe’s study indicated that while there are “450 different approaches to psychotherapy, research shows that actually none of them can prove any more effective So what you do is ‘manualized’ treatment or intervention, and you’re just applying a method, you’re not actually even dealing with a person so it’s totally incongruent” (p. 565).

Interestingly, Gibbs and Gambrill (2002) speak of “process research” which is becoming a wider field of study. Process research looks at moment-to-moment therapeutic interactions with the intent of identifying specific strategies and common processes which result in positive outcomes in psychotherapy. The intent is to look at client change, or “proximal outcomes” which are predictors of overall goal achievement. This is an interesting movement, one which has found little discussion in the literature at this point in its relationship to EBP. By being able to look at these strategies and how important they are in therapeutic change however, we may indeed find a suitable tool of measurement for those therapeutic approaches that are more challenging to measure and do not neatly fit into the medical model.

In 1972, Cochrane talked about outcomes, and made a relevant statement, saying “outcome is not the whole story, the manner in which services are provided, including kindness and ability to communicate” (p. 95) matters also. Gray and McDonald (2006) agreed. Their argument was that a successful social worker requires technical mastery. That the most successful piece of the worker-client relationship, regardless of the method used, is based on the value of respect for clients in that they are worthwhile individuals who can develop their lives even more fully should those clients have the necessary resources available to them. This is a criticism which many people have with EBP in social work. Webb (2001) argued that while EBP favours traditional research, it fails to adequately account for the ambiguities and complications of social work practice. Van de Luigaarden (2009) concurred, finding that the daily experience and practice of social work is a unique and idiosyncratic movement, particularly in relation to culture, space, and place, and in which no two sessions are ever the same.

Blom (2009) argued that it is very difficult to base social work entirely on the concept of “knowing” that an intervention is going to work. While a strategy may be found effective after a small number of randomized controlled studies, this implies that the intervention itself needs to occur in a predictable world, without any other factors influencing the moment. He believed that it is acceptable to make the assumption that not knowing what is going to happen because it is unpredictable needs to be used as an additional approach to social work, as an additional complement to the “knowing” piece which EBP provides. “Un-knowing” also means that social workers need to be open to everything that is unpredictable and therefore impossible to plan for. By virtue of being human, we cannot predict what will happen when we interact with other human beings. Blom also looked at what the individual brings to the practice of social work, arguing that it cannot be based on book knowledge alone. Success also depends on personal

talent and skill, which can be taught by doing and by imitating experienced social workers. The concept of EBP implies that if one has an intervention which is based on research, it should be applicable to a specifically diagnosed individual, regardless of one's experience, or relationship with that person, and it should be effective in symptom or behaviour reduction. Whether this is real or perceived is part and parcel of the question of the movement to EBP and needs to be further explored in order to ensure that effective interventions are being applied.

Despite Blom's (2009) apparent opposition to the use of EBP, he made it clear that he is truly in support of it. The argument is that EBP cannot be the only way of providing treatment, nor should social workers focus entirely on the tools of EBP, as this results in losing focus on the main purpose of the task. The concern is the tool ends up using us, as opposed to the other way around. A main point in his argument was while it would be easy for social workers to reject rational thinking and not doing what they think is right, in favour of being held accountable for reflecting on one's own actions or "gut-feelings." This is an important piece which is continually overlooked in EBP – the concern that the research will outweigh common sense and as a result, perform exactly the opposite of what it set out to accomplish in the first place – to help clients and avoid harm.

Advocates of EBP reject the long standing notion that theory, practical experience, traditional training, expertise or common sense alone or all together provides enough guidance for effective social work practice (Howard et al., 2003). With that being said, there also needs to be the understanding that incorporating an evidence-based perspective means that there needs to be the adoption of integrating EBP in the context of informed professional judgement and sensitivity to the personal preferences of the clients. If a client is not comfortable with an intervention, or if the intervention is not proving to be effective, there needs to be flexibility to

move to a different one. On the other hand, if a professional does not value EBP as the main perspective, there still needs to be an acknowledgment of the necessity of EBP practice guidelines, systematic reviews, and manualized intervention approaches. “Few will dispute that there must be elements of both flexibility and regimen in the treatment of psychological and social difficulties.” (Gibbs & Gambrill, 2002, p. 476).

Implementing EBP in Social Work

Research on the implementation of EBP in social work is not as extensive as required to adequately address the challenges which have been highlighted and to explore how to balance the varied perspectives on how to best meet client needs. Recently, Yunong and Fengzhi (2009) found that the availability of evidence and its ability to be applied with regards to the diverse and unique situations which social workers need to deal with is not examined as much as it needs to be. Support for this assertion also comes from the findings that many of the studies exclude participants with co-morbidities, complex, and multiple problems, who are representative of clients who use social work services (Zlotnik, 2007; Berger, 2010). In addition to this, Patterson, Miller, Carnes, and Wilson (2004) argued that despite the growing need for utilizing EBP in marriage and family therapy, there are few programs which focus on the impact of relationships in mental health issues. There is also a failure to take developmental stages into effect with regards to using EBP with children. Children undergo more rapid changes in their physiological, neuronal, and psychological makeup over a very brief period of time, in comparison to adults. Because this development happens so quickly, any EBP which is utilized with a child needs to take these conditions into account as they will affect the durability of the treatment (Hoagwood et al., 2001).

Given that there is a bridge between science and application, a series of studies (Hoagwood et al., 2001) looked at the efficacy of manual based services for children with serious psychiatric illness, and examined how to better engage the participants in treatment. Findings suggested that identifying what EBP models do not work or result in more aggravated symptoms need to be determined as well, not just identifying what works. In addition, Hoagwood et al. (2001) argued that this research is conducted in a different setting than where treatment is usually provided. As a result, there may need to be adaptations in the delivery of service, in order for the treatment to fit the child, and not the other way around. The variable of environment is one which has created much discussion and debate in the implementation of EBPs, particularly in regards to children's mental health.

Practitioners are expected to identify and use research which is scientifically strong, appraise its application to a specific client situation, and evaluate the client's progress to determine if that intervention was successful (Ferguson, 2003). If the process of implementing an EBP is not completely understood and implemented according to the expectation from the research, there will be even further struggles to continue to assess its subsequent effectiveness. Gray and McDonald (2006) believed that the promotion of social worker accountability to those people who use the services should be a key reason why social workers should fully embrace EBP. The struggle continues to lie in the fact that clients do not always fit into a nicely packaged diagnosis whereby nothing else interferes with the delivery of one evidence based intervention. Given the current state of our professional understanding, Howard et al. (2003) acknowledge that it is impossible to consistently find interventions which have been empirically tested with the same problems or populations which professionals find in real life situations. The authors also believed that EBP interventions should work in combination with existing interventions. There is

also a staunch belief by Howard et al. (2003) that EBP should never replace the judgement of the practitioner because it is the professional decision of what is relevant at the time that will dictate the highest area of need and what needs to be addressed. A practitioner cannot base a therapeutic session solely on a prescribed intervention without assessing what is happening for the client in the moment. Sackett, Richardson, Rosenberg, and Haynes (1997) had the same conclusion, arguing that practice can be diluted by using EBPs alone, without the incorporation of professional expertise and experience. It is debated that even the most compelling evidence can be inconsistent with the needs or goals of an individual client. Sackett et al (1997) balanced this with the understanding that without the use and implementation of best practice in their work, social workers could end up relying on interventions which are outdated. This will eventually will be detrimental to the client.

There is an overall understanding and agreement that EBP is the direction of the future with social workers. There also seems to be a push and expectation that practitioners continue to conduct research not only on their own clients and what intervention is right for them, but also to support the cause as well. Mor Barak, Nissly, and Levin (2001) maintained that the limited availability of relevant evidence-based knowledge amongst social workers is so rarely addressed that social workers themselves are expected to address these gaps. Lunt, Shaw, and Mitchell (2009) concurred with the concept that time for research by practitioners is very difficult to provide, as practical work demands their full attention. What is also stressed is that management support is crucial in terms of practical matters and understanding in supporting the value of research. Very little is mentioned about how caseloads and time constraints factor into this expectation.

For practitioners to then write about what this process was, and to back it up with current research in order to promote the formation of a new evidence-based intervention, as well as using the same design over and over with different people is pragmatically prohibitive. This expectation immediately causes people to react to EBP in a negative manner. Despite the difficult practicality of this notion, the expectation is out there (Mor Barak et al., 2001; Lunt et al., 2009; Anonymous, 2011). Trevithick (2008) claimed that new knowledge should be created through research, and be shared with others, based on personal practice experience. Berger (2010) agreed, suggesting that researchers should get information from practitioners about their “knowledge needs.” In other words, the expectation becomes collaboration between those who generate knowledge and those who apply it. The difficulty again occurs in which no two situations are alike therefore what works for one person with one mental health issue may work for another with the same issue, however when there is more than one diagnosis the barrier then becomes how does extensive research occur.

Co-morbidity

Where do the children who experience co-morbid mental health disorders fit in and how do these children get treatment for such disorders if they do not fit the mold of evidence-based programs? Research has touched on this to some degree however, what is determined and supported most frequently is that the presence of co-morbid disorders corrupts the research. Therefore, children with co-morbid diagnoses are not the ideal candidates for empirically based interventions. In fact, Hoagwood et al. (2001) identified those variables such as co-morbidity, parental substance abuse or pathology etc. as “nuisance variables” that traditionally have been controlled for in an experimental setting. Controlled laboratory trials which focus on the efficacy of an intervention traditionally eliminate obstacles which can confound the research, and the

presence of co-morbid disorders is one of those obstacles. Hoagwood et al. (2001) acknowledge that implementing targeted interventions needs to take such “nuisance variables” into account if the successful dissemination of an EBP is to occur.

It is important to begin with considering how co-morbidity has been understood and addressed within the research literature. The concept of co-morbidity was created by Feinstein (1970), who initially related the term in reference to medical diagnoses, when an individual experiences more than one disease at the same time. Co-morbidity in children’s mental health has been defined as two separate disorders occurring concurrently, (Hranov, 2007). “The presence of more than one specific disorder in a person in a defined period of time,” (Burke, Wittchen, Regier et al., 1990, p. 650); the co-occurrence of psychological disorders (Bubier & Drabick, 2009); and having more than one mental or physical disorder at the same time (Teesson, Slade & Mills, 2009). While there are high rates of mental disorders in individual who experience chronic physical difficulties (Teesson et al., 2009), this current research will be considering co-morbidity only in terms of co-occurrence of psychological or emotional disorders. In particular, this refers to the occurrence of at least two disorders at the time of assessment, meaning both must be present at the same time, regardless of whether the times of onset and offset occurred simultaneously.

According to Anderson, Williams, McGee and Silva (1987), the first quantitative descriptions of co-morbidity between different sets of psychiatric diagnoses only began to be recognized in 1987, and since then, research which focuses on co-morbidity has demonstrated a marked increase. A few years later, Kendall and Clarkin (1992) described the study of co-morbidity as the “premier challenge facing mental health professionals in the 1990s” (p. 833).

Subsequently, a great deal of interest has been taken regarding the prevalence of co-morbidity in children and adolescents with mental health disorders.

Kessler et al. (1994) conducted a survey of the prevalence of DSM-III-R (APA, 1980) psychiatric disorders in the United States in order to determine the estimation of individuals who will experience lifetime and 12 month durations of psychiatric disorders. While this survey did not include children less than 15 years of age, the results indicated that at least half of the respondents reported at least one lifetime disorder, and approximately one-third reported at least one 12-month disorder. One in six of the participants reported a history of three or more disorders occurring at the same time. This National Survey (1994) and the National Co-morbidity Survey-Replication (Kessler et al., 2005) have both demonstrated that mental disorders occur at the same time more frequently than would be expected by chance. In the past, co-morbid disorders have been viewed as a “nuisance variable” (Hoagwood et al. 2001, p. 1190) by researchers, causing difficulties in determining accuracy when attempting to establish efficacy in RCTs. This mindset is slowly shifting, and there has been an increase in the acknowledgement that the presence of two or more mental health disorders can exist simultaneously, and in fact, is more common than not (Kessler et al., 2005; Krueger & Markon, 2006). Part of the difficulty in defining co-morbidity is that some studies have considered diagnoses which co-occur over a relatively short time period, whereas other studies have reported these time lines as being much longer, varying between 6 months and the lifetime of the individual (Angold et al., 1999). It is also important to note that there is nothing in the research which determines that one diagnosis causes another. In fact, part of the concern is that often a person who meets the criteria for a one disorder could also meet the same criteria for another, even if there is no relationship between the two disorders (Krueger & Markon, 2006). With regards to a clinical setting in particular, the

findings have indicated that individuals who seek help for a single diagnosis are extremely rare (Krueger & Markon, 2006).

Co-morbidity has traditionally caused concern for RCTs (Hoagwood et al., 2001) in that treatments are generally designed for a single Axis I disorder, and patients are assessed to ensure that the diagnosis which is being treated is absent of as many variables as possible. The goal is to make certain that a treatment modality is effective for the diagnosis which is targeted. These treatments become manualized and post-measures are conducted to determine if symptom-reduction has been achieved. With this being the nature of EBP, it is quite evident how the presence of more than one disorder can create issues in research. Does this then imply that in a clinical setting, co-morbidity should be treated with one manual for the first diagnosis, and a second one for the second disorder?

Currently, funders for children's mental health require that research proposals are tied to categories defined by the DSM-IV (APA, 2000) in order to be considered for financial support (Westen, Novotny & Thompson-Brenner, 2004) which has, as a result, narrowed the application for funding down to a single diagnosis. Westen et al. (2004) consider this to be problematic as a result. Categories in the DSM-IV (APA, 2000) are created by the consensus of a committee (Bayer & Spitzer, 1985) rather than by empirical methodology, and many of these diagnoses are under critical challenge, resulting in yet another re-write of the DSM (APA, in publication), projected to be published in 2013. Westen et al.(2004) have also identified the concern that clients do not always present specific symptoms of an Axis I diagnosis at the beginning of treatment which can create a misdiagnosis given that some disorders have symptoms which overlap with others (Krueger & Markon, 2006). In addition, current data suggest that up to half of those individuals who seek treatment for mental health concerns do not "fit" in one category,

and often will cross the threshold for another diagnosis. In their research on co-morbidity, Kessler and his associates (2005) found that between 50% and 90% of Axis I diagnoses are shared with another Axis I or an Axis II disorder. A client who presents as being anxious can be treated with an EBP tool, however, if gender confusion is the root of that anxiety, it is difficult to determine whether the treatment will be effective if the root of it is not dealt with.

It is clear that co-morbidity has been difficult to address and will continue to be challenging within the context of EBP given that co-morbidity is generally referred to as a nuisance variable. This highlights the need for more research on addressing co-morbidity in treatment contexts. Studies supporting the development of combining treatments as well as taking into account organizational factors such as case management or involving other community partners in order to support other needs in a child need to be looked at. Blom (2009) agreed that we cannot simplify interventions into one nicely presented manual. Current research on EBP needs to be viewed as still being in the preliminary stages of development, as there are many aspects of social work which cannot be standardized. Existing studies do not take into account the context under which an intervention is applied, as this would make the results unreliable. Despite the push towards EBP, we need to recognize and use our own judgement in acknowledging that what might work well in one context may be impractical in another. Adopting EBP without looking at it critically could diminish the focus of theories of change and theories of human behaviour in social work (Adams, Matto, & Winston, 2009). EBP “offers no theoretical underpinning on which to base activities in practice such as conceptualizing a problem or assessing client needs” (p. 174).

Advocates of EBP reject the long standing notion that theory, practical experience, traditional training, expertise or common sense alone or all together provides enough guidance

for effective social work practice (Howard et al., 2003). With that being said, there also needs to be the understanding that incorporating an evidence-based perspective means that there needs to be the adoption of integrating EBP in the context of informed professional judgement and sensitivity to the personal preferences of the clients. If a client is not comfortable with an intervention, or if the intervention is not proving to be effective, there needs to be flexibility to move to a different one. On the other hand, if a professional does not value EBP as the main perspective, there still needs to be an acknowledgment of the necessity of EBP practice guidelines, systematic reviews, and manualized intervention approaches. “Few will dispute that there must be elements of both flexibility and regimen in the treatment of psychological and social difficulties” (Gibbs & Gambrill, 2002, p. 476).

EBP as a Process

The question posed at the beginning of the review of literature was whether EBP is a verb or a noun; an action or an object. While there appears to be much discrepancy around this, a good deal of the research suggests that it is both, and this is why there is so much confusion and misunderstanding of the concept. The theoretical underpinnings of client-centred therapy are that the client needs to be involved in treatment. It needs to be something that has buy-in, something interesting, something which provides motivation, and an agreement that this is what the purpose of the therapeutic relationship is all about. There needs to be flexibility and thought when preparing a treatment plan for a client. Often, a client comes into treatment with one problem and, invariably, there is a host of other concerns presented in addition. This could generate an entirely different discussion about the length of time in treatment, whether all difficulties are tackled or just the initial concern that the client came in with, and should treatment plans be continually evolving until the client is experiencing no problems at all, or, in the case of youth,

they “age-out” and move onto adult services. This is interesting and is beyond the scope of this research at this time; however, it extends the question of EBP and co-morbidity. When preparing a treatment plan, thought needs to be given to what intervention should be administered, under what circumstances, for what concern, under what conditions and the nature of the population, to determine which intervention has what effect and at what cost (Reid, Kenaley, & Colvin, 2004). While experimental designs can effectively answer some of these questions, all of these variables need to be taken into account.

Gambrill (2006) argued that EBP is an evolving process; a philosophy and new professional educational format that is based on problematic behaviour and is designed to help social workers link evidence, ethics and intervention together. While this is an evolving process, it is not meant to be practiced with total disregard for the client’s unique characteristics and circumstances. Ethics need to play a large role in the implementation of an EBP in that practitioners need to use well-developed moral reasoning (Gray & McDonald, 2006). Mature professionalism is thus implied, which can only come with experience.

Thyer & Myers (2010) conclude that EBP is in fact a process – a verb, as opposed to being a noun. “There is no such thing as EBPs, since in EBP one decides what services to provide by taking into account not only research evidence but also client preferences and values, situational circumstances, professional ethics, the practitioner’s existing skills, and available resources” (p. 24). Thyer & Myers (2010) believed that using the term EBP to refer to a specific intervention is a misuse of the phrase, and that at best such techniques can only be labelled as empirically based or research-supported. The authors argued that this is where the breakdown occurs in that there are so many misconceptions regarding this. Berger (2010) supported this notion, claiming that while there are many inconsistencies regarding the exact nature of EBP,

there is a consensus that standards are necessary to inform and guide practice, as opposed to a specific approach or intervention. These issues have already been identified and acknowledged in psychology and medicine (Sturat & Lilienfeld, 2007) in that there exists what has been conceptualized as a consumer/researcher mismatch between what is researched and what social workers need. A major question is whether social work can adopt such a staunch medical model without modifying this model to be more realistic when emotions and individual personalities, not to mention relationships, are first and foremost in the picture.

Gray and McDonald (2006) described the separation of the two different understandings of EBP as well. They acknowledged that there are supporters of a rather narrow viewpoint who advocate that EBP should be described as a treatment which is chosen based on scientific support given the diagnosis. They also acknowledged the other camp which views EBP as an overall approach as to how the entire practice of social work should be undertaken. Gambrill (2001) agreed that EBP is more of a philosophy of practice rather than a concrete method of engagement. That being said, she also argued that social work practice not informed by evidence is a “recipe for bamboozlement” (p. 170). She indicated that not incorporating interventions based on research would result in practice that would be derived from a lack of implementing ethics, methods of research which are obscure, and advocacy that all modes of social work are equal.

While there are differing views on the implementation of EBPs in practice, there is some question as to the role of theory in implementing EBP. In reviewing the literature, there is seldom mention of theory, with the exception of the perspective of agency theory at some points. Agency theory examines the relationships between principals - the individuals who set the task, and the agents-those who implement it (Shapiro, 2005). Exploring agency theory in relation to

how social work moves towards EBP is crucial to the delivery of service. In order for practitioners to make the shift, decision-makers also need to make this shift, and harmonize their understanding of EBP so that there is less confusion in the delivery of service. Gray and McDonald (2006) discussed that the central problem for principals when implementing change is how to control the agents, and this could be problematic in terms of the dissemination of service provision based on EBP. Waddell and Godderis (2005) reached a similar conclusion, in that despite the attempts to advocate for the use and implementation of EBPs in mental health organizations, such interventions have only experienced mild success and the authors believe that larger organizational system changes need to occur in order to support the shift to EBP.

Finally, the readiness for large scale distribution of EBPs in child and adolescent mental health services needs to be met with a healthy skepticism until research of the fit between EBP and service delivery has been conducted (Hoagwood et al., 2001). While this statement was made over ten years ago, based on the research it continues to hold true. Practitioners and the government bodies which make their funding decisions need to jointly determine what the definition of “evidence” is. More importantly, these same decision-makers need to determine whether there is agreement as to whether EBP is a noun or a verb. Is it an action or a process or both? Does implementing a manualized intervention that has a gold-stamp of approval constitute treatment? What do we do with those children who have been diagnosed with more than one mental health disorder? Do we modify the treatment or not provide any treatment at all when clients do not fit the requirements to make us all look successful, and therefore receive the funding which allows us to continue to implement EBPs that work for a small percentage of people? Ethics need to enter this conversation, and be a part of the determination as to how practitioners treat those very difficult cases.

Given this, there is still a great deal to do prior to global implementation of EBPs in social services and, specifically, in social work and children's mental health. Practitioners need to take a hard look at our belief system in terms of service delivery, making sure we are using "best practices," and giving the client what is proven to be effective. I want to further explore my own understanding and emotions surrounding this, to determine if my resistance is due to not wanting to change, due to ignorance, or due to not being confident that doing what I am supposed to be doing (implementing EBP) is what is best for my clients. I then want to have a better understanding of what my colleagues are experiencing in terms of this as well. Are we doing what we say we are doing or are we doing what we think we need to do?

Chapter 3: Theoretical Framework and Methodology

It can be said that the pursuit of evidence is the pursuit of truth and the pursuit of what truly works; in this case, for children with a diagnosed mental health disorder. Foucault (1980, p. 133) would categorize this as “a regime of truth,” or a more disciplined and institutionalized description of the word “truth.” According to Foucault (1980), ‘truth’ is to be understood as a system of ordered procedures for the production, regulation, distribution, circulation and operation of statements. ‘Truth’ is linked in a circular relation with systems of power which produce and sustain it, and to effects of power which it induces and which extend it; a ‘regime’ of truth. Foucault believed that every society creates its own “regime of truth” based on its own values, beliefs, and mores which have been caused by historical influences. The ‘regime of truth’ is the product of random and contingent discourses which over time come to be known as true, such as in certain societies (Foucault, 1980). The production of truth or knowledge varies over time from historical period to historical period. The ‘regime’ consists of the general politics of truth; the types of beliefs which allow a society to accept what is known as the truth at that given time. The ‘regime of truth’ is shaped and distributed by the discipline – a way in which power is exercised (Foucault, 1977). This is conducted by various groups who create the rules in that particular society, including governments, businesses and agencies, such as non-profit children’s mental health agencies. At any one given moment in history, the discipline will ensure that the ‘regime of truth’ which is held as knowledge at the time, will be exercised in that society. EBP has come to be a current ‘regime of truth’ and has thus been implemented and imposed on our current culture, and is enforced and regulated by the discipline.

While there have been many published reports on deconstructing EBP (Freshwater & Rolfe, 2004; Griffiths, 2005; Holmes, Murray, Perron, & Rail, 2006; Mantzoukas, 2008), most of

these articles are written from the viewpoint of research or of policy-makers, as opposed to looking at this concept through the perspective of front-line staff. I have been exploring deconstructing EBP in children with both single mental health disorders and co-morbid mental health disorders, particularly through the lens of Foucault (1970; 1977; 1978; 1980; 1984; 1991). This is a very difficult task as Foucault disagreed with diagnostics and labels, arguing that this only serves to create a hierarchy and indication that those who have a diagnosis need to be disciplined (Foucault, 1977). A diagnosis thus in turn, requires care. On the same lines as Foucault (1977), Fox (1995) discussed the paradoxical nature of care in that while it is usually viewed in a positive manner, what comes with it is that those who provide the caring also take on a form of control over the person who requires care.

As practitioners, we end up becoming the ones providing care or control of those children whom we have determined need treatment, and thus we are compelled to make a choice when it comes to treating children who have more than one diagnosis. Which EBP do you apply first? Often, we need to look at symptom-reduction, and the symptoms which are most problematic. When an individual has ADHD and depression and has made suicidal gestures, it is very difficult to determine whether to treat the impulsivity first, and then the depression, or the other way around. Impulse control may cause suicidal gestures; however, depression can cause suicidal thoughts. By viewing the construct of the practitioner needing to make such a decision for a client through the lens of Foucault (1977), it would only be viewed as an attempt to control the individual by implementing power and surveillance.

Holmes et al. (2006) explored EBP by drawing on the work of Deleuze and Guattari (1972), as well as Foucault. They attempted to demonstrate that the movement towards EBP is “outrageously exclusionary and dangerously normative with regards to scientific knowledge” (p.

180). The authors particularly looked at the Cochrane Collaboration (Cochrane, 1972), which is often viewed as founding EBP in the medical world. The Cochrane Group (Cochrane, 1972) has created a hierarchy of what is and is not acceptable in medical, and more recently, psychological research, developing a very exclusive list of criteria which determine what is considered to be adequate research. This also serves as a detriment to many other forms of research in that those forms of research do not meet the requirements necessary to enjoy such privileged status, and are thus excluded from being recognized as such. Because of these ‘regimes of truth,’ “scholars have not only a scientific duty, but also an ethical obligation to deconstruct these regimes of power” (Holmes et al., 2006, p.180) Cochrane reviews are systematic, and the intent is to collate all evidence which fits predetermined criteria in order to address a specific research question, and to minimize any potential biases by using explicit, systematic methods (Higgins & Green, 2008). Cochrane reviews are very complex and rigorous, based on RCT designs (Higgins & Green, 2008), resulting in many researchers choosing not to enter into such collaborations, however, these reviews have set a very high standard for subsequent research and EBP.

The Cochrane Group has created and epitomized itself as the top of the hierarchy of evidence and thus, “the regime of truth” (Holmes et al., 2006). The resulting research and specialized journals and best practice guidelines have taken EBP into a very powerful place in the healthcare field, and in this case, in children’s mental health. I will explore the hidden politics of this movement, including: (1) the financial aspect of EBP, and whether the need to prove what we are doing is working and (2) whether pre- and post-treatment measures, should clients not show improvement, can be used to justify cuts to children’s mental health funding. Does this in turn, disallow different viewpoints and different modes of treatment that are not based on RCTs to be utilized, and thus marginalize other forms of work, such as the

professional-client relationship? Griffiths (2005) deconstructed EBP in nursing and agreed that governmentality does not respect any other research paradigm except for RCTs and thus fails to recognize expertise and the real nature of clinical practice, that of relationships and experience. He concluded that it is the selection of questions to be asked and questions to be answered which is the true limitation of EBP by practitioners.

Postmodernists believe that there should be no restrictions on the sources of knowledge used by professionals (Porter & O'Halloran, 2009). The postmodern movement contends that health care is not being as effective as it could be, because of the focus on EBP. The belief is that it excludes all other forms of evidence which are needed to understand the complexities of treatment, minimizes other important aspects of clinical experience, and it fails to take the individual into account. Postmodernists find EBP necessary but not enough to be able to provide sufficient care.

Winch, Creedy and Chaboyer (2002) looked at the Foucauldian concept of "governmentality" to analyse EBP in nursing. Foucault's idea of government refers to all the action plans, or agendas, reflections, and actions which seek to drive the behaviour of others (Foucault, 1991). EBP can be approached under this concept in that it can be argued that the government is seeking to control how funding is spent based on interventions which are used and whether interventions are proven to be effective. A similar parallel will be made here in terms of children's mental health. Winch et al. (2002) argued that it is possible to visualize the governance of nursing and therefore nurses "across two distinct axes; that of the political (governance through political and economic means) and the personal (governance of the self through the cultivation of the practices required by nurses to put evidence into practice)" (p. 157). I have attempted the same exercise, to look at children's mental health through the eyes of

politics: political and finances; and through the eyes of the personal impact one has in providing treatment with children. The personal impact becomes the control of oneself through the expectations required by front line workers to put evidence into practice. This brings into consideration once again the concept of ‘truth,’ and how the ability to govern is based on forms of “truth” (Winch et al., 2002).

The notion of truth begs the question ‘what comprises evidence?’ What makes one piece of evidence count and what causes another piece to be discounted all together (Holmes et al., 2006)? Foucault would call this question a subjugated knowledge. Foucault (1980) defined subjugated knowledges as:

...a whole set of knowledges that have been disqualified as inadequate to their task or insufficiently elaborated: naïve knowledges, located low down on the hierarchy, beneath the required level of cognition or scientificity....It is through the reappearance of this knowledge, of these local popular knowledges, these disqualified knowledges, that criticism performs its work (p. 81-82).

Holmes et al (2006) argued that an evidence-based world view is oversimplified in that it fails to take into account personal and interpersonal connotations of a world which is fundamentally based on relationships. Foucault would have difficulty with this statement, and would have argued that a therapeutic relationship is based more on a power relationship and that one person would need to take on the subordinate role, and that would be the client (1980).

In children’s mental health, the discipline, or the people who fund EBPs, do not seem to find the question as to what defines evidence to be of any particular importance. This question interferes with the ability to govern based on the ‘regime of truth’ as the discipline has come to believe. Government is known as a discipline which has credibility and is comprised of experts, and the front-line staff who implement EBPs are marginalized and discounted as a source of knowledge.

Government, or control of oneself, depends on expertise and experience, and for Foucault, the self is an historical and cultural occurrence shaped through discourses which include practices (Foucault, 1984). Dynamic adaptations of the self involve taking up ways of being that are suggested within a culture or social framework through codes for behaviour (Foucault, 1984). Thus, practicing evidence-based therapy in children's mental health requires therapists to do more reading and research, perform pre- and post-intervention measures, attend training, implement new interventions, and supervise one's own actions accordingly. This then results in a form of governance which causes a reshaping of one's professional identity. A positive outcome of this is what was previously mentioned in this paper, the movement of social work into an area in which there is greater acceptance of the profession as being more scientifically based, therefore more respected and appreciated.

Foucault (1970) considered human sciences to be a "dubious discipline" (Gutting, 1989) and believed that such sciences were consistently simplifying themselves instead of making itself more well-defined, arguing that human sciences were imprecise and too relative. While he was not in favour of the concept of science as a whole, he nonetheless believed that human sciences did not meet the criteria of objectivity or methodology, the formal criteria for any scientific form of knowledge. In fact, Foucault did not think that human sciences should be considered science at all. Foucault (1970) referred to human sciences as being in a "metepistemological position" (p. 355) in that it is limited in its attempt to be exact, they change with circumstances, and are based on perception. This is an interesting concept in that the movement to EBP goes against the grain of what Foucault determined to be what human sciences represented, and that given this, it is doubtful that he would be in support of this progression. He was not in support of so-called 'experts' telling people how to live their lives (1977).

Despite that Foucault (1977) did not agree with the power-relationship in a hierarchical sense, he sought to terminate the viewpoint of the effects of and impact of power as being entirely negative. He believed that power is a much more substantial force than what is required and driven by economic importance alone. He believed that “power produces reality; it produces domains of objects and rituals of truth” (p. 194). Foucault (1977) thought that knowledge is a form of power, and argued that knowledge can be gained from power and power can produce knowledge (Mason, 2012). In this sense, EBP can be viewed as an entity which is informed by knowledge and the more knowledge gained around this construct can result in the more power for which EBP will possess.

The other component which continues to be diminished with the use of EBPs is the voice of the client in implementation of such practice. There exists a power relationship in the practitioner-client rapport which needs to be acknowledged and addressed but is often overlooked. It is a power relationship that should be attended to, particularly considering there is potential for oppression and coercion (Scheyett, 2006). Scheyett (2006) participated in an analysis of the Evidence-Based Care for Persons with Serious Mental Illness (EBP/SMI) Initiative in the US (Calhoun, 2002) through a Foucauldian lens and identified some interesting concepts. Specifically, she explored three major Foucault themes: silenced voice; moral fault; and power and knowledge (p. 92). The EBP/SMI initiative was designed to identify EBPs for adults with serious mental illness. It identified six EBPs with the intent of developing and disseminating training materials to practitioners of mental health care (Calhoun, 2002). The most impactful observation was that Scheyett (2006) did not find any room in the initiatives which were explored for the voice of the client nor for the struggle that the client experienced. She found that EBPs are based in a hierarchy which does not acknowledge the substance of client-

first person accounts in that the clients are not heard and do not count as “evidence” (p. 75). This then removes the qualitative aspect of research and results in the researcher only focussing on quantitative facets.

The concept of power and knowledge are intertwined according to Foucault (1980), and Scheyett’s (2006) analysis also speaks to the hierarchy of the practitioner/client relationship. A relationship in which the practitioner becomes the person responsible or ‘in charge’ of the client’s treatment, which is counteractive to the concept of respecting the rights of patients to make decisions about their own treatment. Along this line, Foucault (1980) again suggests that research is a privileged position and thus EBP is therefore a knowledge “reality;” however, it is forced upon clients who are not so privileged and have very little power in comparison (Scheyett, 2006).

Two other aspects of Foucault are the ‘gaze’ and panopticon (Garrett, 2005). A panopticon is a high-surveillance prison with cell blocks which are situated around a central area, which gives the ability to monitor all of the prisoners at all times; however, the prisoners do not know if and when they are being observed by their captors. This principle also is found in social work, as it allows the funders/government the ability to have close supervision of professionals and ensure that they are utilizing what they are being funded for. The ‘gaze’ is a lesser component of the panopticon, as it is more focussed on an individual, but has the same monitoring ability. By virtue of a diagnosis, the client is thrust into a category and therefore allows practitioners to treat that diagnosis, but also gives them the ability to hide behind the privilege and power of what is offered as an intervention: the EBP which is administered (Keenan, 2001). The ‘gaze’ in Foucault’s (1977) perspective is that professionals are watched firstly by the client and then by managers as they provide a continuous review of what the client

needs. The 'gaze' continues on a larger level, as management ensures that EBPs are being implemented, report this to upper management, who reassure funders that indeed, the funding which is being provided is going towards where it is supposed to be. Foucault (1977) found that this form of surveillance 'clearly indicates the appearance of a new modality of power in which each individual receives as his status his own individuality, and in which he is linked by his status to the features, the measurements and gaps, the 'marks' that characterize...and make him a 'case' (p. 192). Services provide a plan for the 'conduct of conduct' (Foucault, 1991) which is dominated by power and knowledge and is implemented by the decision-making of managers. The 'conduct of conduct' serves to reinforce the perceived inability of those with a diagnosis to manage themselves without intervention – there is an implication that the client has freedom to choose, however they are not adequately equipped with the ability to make a choice.

One cannot talk of Foucault (1991) and his notion of governmentality and power without looking at the concept of resistance. Foucault stated “where there is power, there is resistance, and yet, or rather consequently, this resistance is never in a position of exteriority in relation to power” (Foucault, 1976, p. 95). He viewed resistance as not just a single reaction to a course of power, however as a result of multiple reactions over a course of time. Armstrong (2008) understood Foucault as stating that resistance is guaranteed by a groundwork that was previously laid, which begins to escape the powers that trap it from the outside. She also found, however that Foucault altered this theory in his later work and determined that resistance is produced by the very power that it is resisting against. In relation to EBP, resistance to this movement can be viewed as inevitable as it will always happen, as no one fully complies to truth as it is dictated through discipline, and alternate movement will occur. While EBP has been branded the new

way of providing treatment in children's mental health, it is to be expected that the pendulum will inevitably start to swing the other way.

As a result of her analysis of the EBP/SMI initiative, Scheyet (2006) concluded that in an effort to incorporate EBPs into practice, many professionals have not carefully examined its costs, which can be excessive. "EBPs, as they exist currently, may decrease symptoms and improve some outcomes, but do so in a way which can be oppressive, paternalistic, stifling, and that may ultimately lessen chances for recovery (rather than simple stabilization)" (p. 83). Holmes et al. (2006) had similar viewpoints and argued that an evidence-based world view is oversimplified in that it fails to take into account personal and interpersonal connotations of a world which is fundamentally based on relationships. In my autoethnography, I will look at EBP, in terms of the literature, my own autobiography, and the survey results, through the lens of Foucault.

Methodology

The present study employed a mixed methods research design that utilized an autoethnographic approach. I examined my own experiences through autobiography, and I then explored the experiences of my colleagues via surveys. Finally, I applied an autoethnographic approach to analyzing the literature, my own autobiography, and the survey results. I initially completed an autobiography, based on my professional experiences working with EBP, exploring my emotions around using EBPs with my clients, and my understanding of EBP as a practitioner. I completed this prior to the second part of the study, that of surveying my colleagues. Because I wanted to determine if my thoughts and understandings are shared with colleagues, I explored the same experiences of my colleagues through an online survey. I then analyzed the data for themes, differences, and similarities. Based on this research, a report will be written which will summarize my conclusions, so that the participants in the study will have

feedback as to the results, and the clinical management team will be provided with that same report, in order to be able to determine future training needs, if any, for the staff as a whole. While I have my own opinions and experiences with regard to EBP in children's mental health, I wanted to determine whether I am indeed alone in this struggle, or whether my fellow colleagues have experienced similar practical concerns. I have been curious as to how my colleagues view the concept of EBP. I wanted to know if the same degree of naivety and questioning occurs for my fellow mental health practitioners as it does with me. I wanted to determine if other people struggle with the way they do business and try to implement EBPs as part of their treatment plans? What about their work with children with co-morbid mental health issues? These are some of the questions I asked myself first, and then I asked them of my co-workers.

Autoethnography: Rationale

As noted, the autobiographical piece explored my own experiences with EBP and also the experience of my return to formal education. While I looked at EBPs, I recognized that there were parallels between my experience of going back to school, and the implementation of EBP in my field of work. I wanted to examine both, and examine these in a discussion which intertwines the literature with the survey results, in an autoethnographical format.

There are several different ways to write an autoethnography, and very few rules which currently exist (McIlveen, 2008). This is because it is the meaning of the story that is important, rather than traditional senses of scholarly editing. Interestingly, the writer may use a number of different methods to demonstrate the emotion of the research that he/she is trying to capture. Visuals such as photographs, old memoirs, and even self-reporting through diaries and audio-visual means have been utilized to demonstrate what the author is trying to relay on an empathic

level. Triangulation through other means, such as interviews with individuals who could support emerging themes or conclusions, can also provide a powerful piece (McIlveen, 2008).

Traditional researchers have taken the personal and subjective part out of research, and this is the model that I grew up with. I was quite surprised to hear of autoethnography while taking a qualitative methodology course for my graduate degree. I was even more surprised to hear how appreciated and respected this mode of research has become. In the past, and even in the present, research has been at “arm’s-length” from the researcher. The researcher has been required to take themselves out of the project, to minimize themselves and to see the self as something which could contaminate the data. Researcher bias has been a factor to be accounted for and subjectivity has been put aside and minimized thus denying the researcher his or her identity (Wall, 2006). Recent challenges to these theories have resulted in the concept of autoethnography and keeping the researcher as part of the study. This particularly holds true in social research, in that it is extremely difficult to “pretend” that the researcher exists outside of the project itself. By virtue of there being something which is being researched, there is naturally a person who is attached to the outcome. Ellis (1991) believed that a social scientist who has lived through an experience and has felt an emotional connection with it will have exhausting unanswered questions about that experience, and that this alone can be a valuable and powerful research tool. She contended that this should be an acceptable practice as much as it is acceptable to study anything where the $n = 1$. Autoethnographies “are highly personalized accounts which draw upon the experience of the author/researcher for the purposes of extending sociological understanding” (Sparkes, 2000, p. 21). Autoethnography can still be grounded in science; however, it brings a deeper meaning and interpretation of humanism with it, as opposed to research which traditionally has been conceived as being without emotion and entirely objective.

Ellis and Bochner (2006) are considered two of the pioneers of autoethnography, and these authors conceptualize the process very nicely:

Autoethnography shows struggle, passion, embodied life, and the collaborative creation of sense-making in situations in which people have to cope with dire circumstances and loss of meaning. Autoethnography wants the reader to care, to feel, to empathize, and to do something, to act. It needs the researcher to be vulnerable and intimate. Intimacy is a way of being, a mode of caring, and it shouldn't be used as a vehicle to produce distanced theorizing. What are we giving to the people with whom we are intimate, if our higher purpose is to use our joint experiences to produce theoretical abstractions published on the pages of scholarly journals? (p. 433).

Those who like and support autoethnography argue that it is more reliable than other traditional forms of research because of the use of "self," and that the voice of the insider is much more authentic than that of the outsider (Reed-Danahay, 1997).

Despite the support for autoethnography, Sparkes (2000) acknowledged that the status of achieving the title of "proper" research continues to be difficult to attain. There continues to be an underlying belief that personal experience or commonsensical feelings are not socially sanctioned in the same way that expert knowledge has been. Duncan (2004) agreed, finding that a great deal of criticism has been aimed at the more experiential and experimental forms of autoethnography, where artistic expression takes more of a license than analysis grounded in theory. She postulated that there must be a mixture of an emotional response as well as a scientific approach. I agree with this model and am thus not only drawing from my own personal beliefs, experiences, and emotion, but also a theoretical approach in that I am attempting to evaluate a scientific knowledge base (EBP) and its practical considerations. Determining the understanding and experiences of my colleagues also will either support my own feelings and thoughts to one degree or another, or I will discover that I am alone in my feelings of confusion and will need to find some personal and professional ways of dealing with this.

Survey

Given the multiple definitions and forms of EBP and its dominance within the Ministry of Children and Youth Services, it is essential to consider how EBP is being adopted and understood among front-line agencies. Employees at a children's mental health agency in Ontario were surveyed online, anonymously, to collect information to determine the understanding of EBP from other practitioners in the same field. I sent out a questionnaire via Fluid Surveys, to 100 full-time employees of a children's mental health agency, who were in charge of creating and implementing treatment plans with the children with whom they work. I had hoped to yield a high return in that all of the surveys were anonymous and confidential, with the only remotely identifying factor being the number of years that the employee has worked at the agency. The reason I needed to know this was to determine if there is a correlation between experience and knowledge of EBP. While other variables would be of interest, such as whether the participant is management or staff, the importance of anonymity outweighed the importance of knowing this piece of information.

There were many special considerations that needed to be taken into consideration given the nature of this type of survey. The agency surveyed is unionized, and had recently undergone a very stressful bargaining period which resulted in a new contract – much the same as many other professions across the province. I needed to be sensitive to the fact that some people are concerned that there may be an ulterior motive around the timing of this type of survey. Some people may have interpreted it to be a questionnaire of performance ability, and may have not wanted to complete it out of fear, as a result. Every effort was made to reassure participants that this is primarily for research towards a Master's degree, with no other reason for it being

conducted. This was why there was no further questioning regarding personal experience or identification as management or staff.

I sent out an initial email to 100 employees of a children's mental health agency, explaining the purpose of the study and inviting them to participate in it via the electronic letter of consent. In that e-mail, I provided a link to the survey at Fluid Surveys. The twenty question survey consisted of Likert scale questions with additional requests for comments as well as definition questions and a final question asking about the time that the individual had worked for the agency at which they were employed. There was little risk involved other than the fear of exposure, and concern about sharing thoughts and experiences that management will read in the report which I will send out to the agencies as a courtesy. These fears were addressed by reminding participants to share only what they felt comfortable sharing and by the anonymous nature of the survey. The survey is included in the Appendix.

Chapter 4: Autobiography

“Oh my God, what have I done???” While this is what I remember as being the last line from an obscure movie called KIDS (1995) it actually is not. This is what I recall one of the teenagers saying after he, a bleary-eyed young man, who had the AIDS virus, raped a girl who was passed out on the couch beside him. No thought goes into his actions other than a drug-induced decision that this would give him what he needed at the time. A boy who was struggling throughout the script with his lack of future because of reckless sex and drug use, now just realizes in a quick climactic moment, that he very impulsively made the decision to infect another, innocent person, with his selfish, immediately-gratifying behaviour. Because he could. Because it was there.

For whatever reason, regardless of the fact that I unconsciously embellished this last line, this quote continually sticks in my head when I think of an impulsive move on my part or even one that I have thoroughly thought out. Oh my God, what have I done. Throughout my graduate school experience, I have said this idiom many times, wondering what I have done to myself. This is a movie I remember watching several years ago, while working in a treatment facility for teenagers with mental-health issues. These were street-wise teens, and had been a part of the process of carefully choosing to rent this for “movie night” as it depicted apparent real-life actions of children on the streets these days - or should I say, in those days. That was probably 15 years ago however it feels like a lifetime ago.

I was 32 and I had an honours BA in psychology which I was using in my career as a youth worker in a residential treatment centre, working with teenagers. They are the ‘kind’ of children that I would describe as having no problem telling you where to go and how to get there, for no particular reason. I believed that I was making a difference in their lives. I believed

that it was not the children's fault, rather their parents were to blame. I told myself and others that I was a professional, that I did not get "enmeshed" in their lives. After my shift was over, I punched out, and carried on with my life until I punched back in again. At the time, I missed the irony that my social life consisted of hanging out with other people I worked with, talking about the lives of the children we dealt with and the agency I worked for as a whole did the same thing at the time. The residential staff were merely a sub-cast of the larger picture of people who engaged in some of the same behaviours that we counselled the youth that they should not engage in. It was alright for us; we were adults and put up the front that we were all professionals. We were paid to teach the youth about appropriate behaviours given their stage in life. Looking at this now.....I don't get it.

Zoom forward fifteen years to the fall of 2010 and I am in a cubicle at work. This is a space to which I have been relegated because I decided to apply for a pilot project which is three years long, instead of staying put as an Outreach worker and sharing an office with walls and a door with another professional. Why would I trade in walls for a cubicle, at 47 years of age? My colleagues in this program are young, fresh, female, 28, and all have just gotten married in the past several months. I have two and a half more years to go on this pilot project and while it is not as rewarding as some other positions I have had, I chose to apply for it and accept it anyway. The reason behind this is because it is a Master's position and I get paid as a *therapist*. I can now officially call myself a therapist, because I am doing a Master's position and working on my Master's of Arts in Child and Youth Studies. When I was an undergraduate in psychology, my fellow students and I used to make fun of the other students who were in Child Studies. They were the people who used to sprawl out on the floors in the dorms with their construction paper and scissors and make things to hang on Kindergarten walls. I thought that I at least back then,

was doing something more important. I continued to feel pretty important while I worked in residential treatment, especially because I had an undergraduate degree, and most people I worked with had “only” gone to college. For whatever reason at the time, I felt an air of superiority. Conversely, I felt a little lost because my peers had hands-on experience because of the nature of the college diploma they had. Looking back, my air of superiority was likely a reaction formation due to lack of confidence and ability at what I was doing. I also felt that I had more drive to work my way up than other people did, mostly because I was tired of feeling belittled by those who had more education than I did and simultaneously, I had a four year university degree (including Grade 13) which I felt should trump those with a college diploma.

As years went on and my experience in residence grew, I thought I could do what the family therapists did, only better. Better because I wasn’t reading out of a book, like I felt that therapists did at the time. Better because I knew more, I thought, and because I had front line experience, something I did not believe many of them had, at that time. After a period of working shifts dealing day to day with the youth and with their families, I had the opportunity to work as a Family Worker with the children in residential treatment. This was a rewarding experience and one which I felt I was good at, and one that I thought that I improved at over the course of the five years or so I acted in that role. After an amalgamation of the agency I worked for and another one, it was determined that there was no longer any need for a family worker designated to residence, and I was moved to Outreach Services. This was a serious blow to my ego, and I felt quite demoted and demoralized at that point. It was a true turning point in my career. I would go into people’s homes and teach parenting skills and anger management and all that stuff which goes along with moving families forward, but it wasn’t as satisfying as the

Family Worker position. I was quite righteous in feeling that I could do the job I had been doing, despite the lack of a Master's, which I thought was the reason for the move to Outreach.

After working a couple of years in Outreach, I had the opportunity to do a maternity leave position for the therapist who worked directly with the families in Day Treatment. This was a school-based treatment program which was a combination of education and behaviour/mental health treatment. It was designed for children with severe mental health issues that cannot be managed in a regular school setting. After some political movement as I did not have a graduate degree and it was a position that required one, I was offered the position and gratefully accepted, yelling "YES!" into the air the second that the manager hung up the phone after offering it to me.

I had a legitimate Family Therapist position, despite not having a Master's degree. It was made clear to me that I would not be able to be in that position full-time when the maternity leave ended; however, I was hopeful enough that management would make an exception. When the maternity leave was over; the former therapist never came back, and I went back to Outreach. I was told by someone that I had become too involved in the day-to-day business of Day Treatment, and that if I had a Master's degree, I would be "above all that." Flash-forward to a few years later and I am a therapist, but only on a contract while completing a pilot project that more than likely would not be renewed, and I would again need to go back to Outreach once the contract was complete. This was not where I wanted to be, so I needed to make a decision, and I decided to return to school. I have now realized that I cannot become a full-time therapist without a Master's and I struggled with where to start.

A Master's of Social Work would have been ideal however there was nowhere close enough to where I live which offers that though. I could commute to Buffalo; however it was

very expensive and required a six month placement, which I could not afford to do. I wondered if the last twenty years of experience accounted for anything however in my exploration, it did not appear to. I would also have needed to attain a Bachelor of Social Work before I could attend a Master's of Social Work program, so that made it somewhat prohibitive. I explored the MA's in Counselling in New York State as well, however these programs were also expensive, and I would need to do a placement, once again. I have an undergraduate degree in Psychology from Brock University, so I looked to see what Brock was offering that was physically possible for a person who hasn't been in school for 25 years, has an 8 year old nephew (and his father) living at her home, is married, and is working full-time. While the Master's of Applied Disability Studies has been lauded and other people from the agency I work for have taken it, I did not believe that it would be a good fit for me.

I explored the Master's of Arts in Child and Youth Studies (MA CHYS), and I liked some of the areas of research that the professors and students were involved with. It sounded like something that should be quite pertinent, and a placement was not necessary; however, I would need to write a thesis. Daunting, but it was attainable none the less so I conducted some research into the program, spoke to some professors, put all my eggs in this basket, and applied. The application process was interesting and frightening. I needed to submit my marks from twenty-five years ago and was asked me for a research question which motivated me to do research. Graduate Studies wanted a paper from twenty-five years ago, requesting me to "just email it to us, please." E-mail a paper? I could not find a paper in the basement, let alone on the hard drive of a computer that I did not own twenty-five years ago. I felt a little panicked, and emailed them a letter, respectfully pleading for me not to have to submit a paper because I could not find one and it had been years. However, that did not matter to them. Finally, after more searching

through the boxes in the basement, underneath the 45's and 33's, underneath the German Pub Night hat and mug, and underneath the Brock Press with the picture of my old boyfriend on the front cover, I found a couple of fourth year psychology papers. While I had no absolutely no idea what those research papers meant when I re-read them, one of them looked good. I had received 78% and some pretty nice comments, and I hope that it would do, so I submitted it.

I found an old copy of the APA manual which I thought I had memorized back in the day when I used to have to type all my papers out on an electrical typewriter. It was a high-tech machine from 1982 when I went home to Sudbury for Thanksgiving and pleaded my parents to buy me one that you plug in instead of have to manually reset the cartridge on at the end of every line. My gold-colored electric typewriter even had the kind of ink roll that could be used to white-out mistakes if needed, by the mere press of a button. I had gotten used to using a computer effectively since that apparatus, so while finding the paper was miraculous in itself, it was also reassuring that returning to university would not include returning to as barbaric an instrument as a typewriter.

I remember having been in my fourth year of psychology, and computers were new, but very large and cumbersome and exorbitantly expensive, using paper which was very wide and had the perforated strips down the side that you used to peel off when you had finished printing. My fellow students and I would take those stacks of paper, usually one-hundred pages at a time, and go to back to the dorm to analyze the data. Everything was in tiny little 'x's' which illustrated what may or may not be significant. At the time, however, I supposed that this is what research was about. From those printouts, we would gather the data that we needed and analyze it with some type of mathematical formula we conducted by hand. I spent every moment of free time in the library going through the "stacks," which were the journals which we had to explore

in order to find good research pieces and good articles. Then, if we had enough money, we could photocopy them and take them home, and highlight what we needed and use them in our paper, writing everything up before the all-nighters that we would pull to get them typed up and submitted on time. And I wanted to go back to school to get a graduate degree. Oh My God, what have I done?

A Master's degree. I would need to take it part-time and continue to work full-time. "How hard could it be?" I asked myself. Outreach was not the position I wanted to be doing anymore, nor was any other front-line work that I could do with a BA which is outlined in our Collective Bargaining Agreement. I wanted a desk, walls, lamp, a nameplate on my door, and most of all, I wanted respect. I told very few people that I applied for this program, because I could not handle the humiliation I know I would have experienced had I not been accepted. I had resigned myself to moving from the position that I really enjoyed-- the Family Therapist for Day Treatment- - back into Outreach, because of my lack of a Master's degree.

The day I received notification that I was accepted into Brock's MA CHYS program was the day before the final team meeting in which the manager thanked me in front of my colleagues for the "wonderful" job I had done filling in a maternity leave, at the same time telling the team that I wasn't able to stay in this position. There was talk of changing the position to be more effective as it was a very busy position, with a lot of case management and not enough treatment as a result. I asked if I could say something at that point, and let the team know that I had thoroughly enjoyed my time with them, and that I had just found out last night that I was accepted into the Brock MA program and that I would be sure to rejoin that team after graduation. My colleagues congratulated me and the manager looked surprised and, I think, (and want to hope) lost for words. Thus began my academic journey.

That September, I began to work on my graduate degree and I was scared out of my mind. What became so perplexing to me, however, is that it was me who was required to do the work, and there was a lot of it. I had hoped it would be easy, however it was not; it was difficult, very difficult at times. I was grateful when I went to the orientation and met a wonderful group of young (age 24-25) women who were doing the same thing as me – working on their Master's degree.

In that first year, I discovered that it needed to be, and it was me who went to two 3 hour classes a week and completed the readings and paper work for the courses I was taking. It was me who struggled with coming up with a thesis idea, and it was me that changed my mind what feels like a hundred times as to what I was going to do. Quantitative, to qualitative, to applied, to ethnographic to auto-ethnographic. While I no longer needed to find out what floor the Journal of Developmental Behaviour is on, I needed to learn to negotiate the library on-line. It was me who needed to gain knowledge of how to add margins to the computer and do a Running Head and re-learn the APA (2010) style of writing. One space after a period instead of two? It was me who needed to determine what I wanted from this MA so that it is not just a piece of emblazoned paper presented to me along with several hundred people other, It is me who will frame and mount this degree and hang it in my cubicle right next to the Certificate of Prevention of Violence in the Workplace Training (2012) and the piece of paper certifying that I went bungee jumping in 1992.

This has been a journey, and it is me who is taking it and me who owns it. It is an investment and a commitment, and something I have chosen to do because I have wanted to, because I have been compelled to do, because I need to do it for my own self and my own self-respect. It is not that I could have not gotten by without it; I would continue to work, but

probably not be as happy at my job and my career as I would be having attained this level of education. I recall that same phone call from the manager of the day treatment therapist position when I was offered the job..."perhaps this will inspire you to go back to school to do your Master's," she said to me. Riiight, I thought at the time, *sure* it will.

The struggle with what to research and write for a thesis was just that, a very difficult struggle. All of my co-students had an idea which was pretty much embedded in their heads. Many worked with a professor who was in the middle of a major project and had their student help with it, or conducted a study that was based on their undergraduate thesis. I felt alone, struggling to think for myself. I had some ideas about what I wanted to do, and I was looking at Day Treatment. First, it was a case study on a 9 year old in Day Treatment who had a severe anxiety disorder and for whom the system had failed drastically.

Then, that changed, and because I was back in Outreach, I looked at Outreach clients, and thought of formulating some kind of EBP which would work with transitional youth as they moved out of their home. Then, I had the voices of my superiors filling my head about what they thought I should study. I changed my mind over and over and over again. I was involved in a pilot study and thought that maybe I should research that more intensely. Then I fell in love with another therapeutic modality called Interactive Behaviour Therapy (IBT, Tomasulo, 1999) and wanted to look at combining the pilot project treatment with that treatment modality, and conduct a quantitative applied study and see what components are most effective, particularly with the Day Treatment population. I wanted my work to feel important, to give me the respect which I believed that I deserved from my superiors. I was tired of feeling that people thought that I meant nothing because I did not have a Master's degree. I felt continually disrespected because I had a cubicle and that our pilot project was the only program which has no walls or doors.

Because we were a pilot program it felt that we were not worthy of the investment. Those were my personal feelings and, once again, looking back, I am not so sure these feelings were substantiated.

I wrote my thesis proposal up and completed a power point presentation to show the prowess of my new skills on the computer. I picked my committee and was shocked that professors were actually interested in what I was doing. Applied, quantitative, pre-measure this, post-measure that... it was initially too big, so I needed to go back to the drawing board. Too quantitative, resulting in another reconfiguration. I was asked why I wanted to do an applied piece with the Day Treatment children, and was told there were too many variables, too many ethics, too much this and that and not enough time. What about ethics? External reviewer? My clinical director suggested that it would give me a nervous breakdown if I were to pursue it as it was and this surprised me. "Seriously?" I thought, "but I want to make this something meaningful" and it was suggested that I do "something meaningful after you get your graduate degree, it is only a Master's thesis, not your life's masterpiece." I was perplexed, once again, stating "but it is supposed to mean something. Perhaps I might want to publish it and want other people to keep researching my question." All I really knew was quantitative, so I thought I would do some observations and have parents keep journals and involve some of my colleagues in this and and and and....but I can do this, I know I can. It was truly exhausting.

One of my committee members met with me, and asked "What do you really want to study, Sue?" I tell her "I want to find out if there is a more effective impact on children with co-morbid mental health issues when this evidence-based model I'm using at work is modified and components of IBT (1999) are incorporated into the therapeutic delivery. And I have this great plan to do it..." After we spoke, I agreed to cut out the control group, and just focus on parents

and children. “Why do parents?” I am asked. “Um, well, why not? I think there will be more of an impact if I include them.” “And you are still using quantitative measures?” I rebutted “Well, yeah, that is what I know and these will be meaningful this way.” She asked “What about qualitative?” I started to become frustrated, feeling unheard and I thinking at the time that I knew what I was talking about. I said to her “I told you already, I’m getting observations and I’ll do interviews and I know about this new tape recorder which will translate spoken word into written word and, it will be less time consuming.”

I was asked what my research question was. I repeated myself “...the children in Day Treatment do not respond very well to this program so I want to figure out a way that will be more helpful to them, and I love this IBT model which I am sure will help.” That was all I wanted to do; to see if that works. I was discouraged in that it was already November and I had still had not submitted to ethics, even though I thought I was finished my proposal at the end of September. It seemed all very simple to me, and all that I felt was happening was that I kept spinning my wheels.

I entered into yet another meeting with the same professor, having read the dummed-down version of Qualitative Research which she had so graciously lent me. “Okay,” I thought, “I understand. I’ll focus more on observations and that kind of thing.” She again asked me what my question was and I repeated myself. “Did you ever hear the story of the babies floating in the river?” she asked me and I shook my head. “Okay,” was her reply, “you are near a river, and all of a sudden this baby is floating down it and you jump in to save it. You just get to the shore and then another one floats down it so you rush to save it. And then another, and another, so what do you do? While I was not sure where this was going, I bit “...umm, what do you do?” “Go upriver,” she said, “and see what is causing them to be in the river in the first place.”

She went on to explain that I was looking for a reason why a treatment was not working with these specific children. That maybe there is more to it than that. That maybe it's about what is happening in Day Treatment isn't being effective as a whole, and not just a piece which is dealing with anger management, which is what the pilot project I was working with focussed on. Hmmm I wondered....now THAT was a loaded statement! She asked who I could interview and receive honest answers from, meaning the people who work in Day Treatment. I told her that there were four counselors, and three teachers as well as the management team. "How many altogether?" she asked. "Maybe ten," I stated. "Perfect!" she exclaimed, "what a great number!" I am concerned, and asked her what to do with that number. "To interview, and ask questions about and find out what is not working and what is and ask them if they were king of the world for a day, what would they do differently? What an interesting piece of research, she says...now THAT would tell your story! You can analyze for themes and for commonalities, and back it up with research, and you have a great thesis!"

I was surprised by this, as I wondered where the pre- and post- measures were, where the tests and the parents and the children were and the applied piece was, bewildered that I did not need all of that in order to have a decent research paper. She suggested that I think of how valuable this information will be to the school board, the agency, the staff, and to people who may be interested in getting into this field. All of those people would have a first-hand account as to what it might be like to work with this population, and how to make it better. I think it is an interesting idea; however the parameters worry me. I was afraid that I would offend a lot of people, and they will become defensive, and it will be misinterpreted that I would be doing an expose and would lose my job. I explained this to my professor and she countered by suggesting that it was MY project, and that I will not do anything with the information, that it is just

interesting information to learn. And to analyze, and that maybe something might come out of it and maybe not. “It is just about doing something you are interested in. Also, by not using children, you are able to get past a whole pile of ethical concerns that might have held you back, so we could have ethics going very quickly, and get you going on this. Go home and write your story.” I felt bewildered.

I read them, and then I started to write. I believe that I am a fairly effective writer, after having filled out hours upon hours of residential logs back in the day and after doing case note after case note, trying to capture what happened in a family session while being brief, succinct, and detailed all at the same time. So I wrote. And while I was writing I started to see some themes. I saw the theme in my ambivalence and confidence within myself as a therapist, and how this translated to me as a graduate student. I saw themes in wanting respect and looking for ways that I felt disrespected. I saw themes in which I felt that I had unfinished personal business with the Day Treatment program and that I wanted to go back and take care of that, the same way I believed that there are things I could do to help that program work more effectively for the children it serves. Perhaps that was the underlying issue; the answer to my question. The reason the babies were in the water in the first place. What if the reason that the Day Treatment program was not being as effective as it could be is because we were trying to make one treatment fit everyone. Or maybe because we were not being creative and looking at combining different treatment modalities to be more successful. Or maybe it was because having a Master’s degree was not what was sufficient. I had questions, and I needed to find some answers.

I started to do some further exploration, and made another quick stop to meet with one of my committee member’s office to explain the shift in my focus. She was surprised when I told her that I have gone from quantitative to autoethnography and would be focusing on Day

Treatment as a whole and she expressed concern about boundaries. I had not thought of this angle, and I did not like the murkiness of the swamp which I was dipping my toes into. I was not looking to expose the agency I have been working for – having worked there for over twenty-two years and I could not afford to be let go, especially not in the pursuit of higher education. I wanted to figure out how something which is working well can work even more effectively and efficiently, not be disrespectful of something which I had no intentions of being disrespectful of, particularly when this was not what was meant. I understood political toes as far as I was able to anyway, and had no intention of stepping on any. Oh my God, what have I done??

After yet another step back and a few more meetings with academic minds, as well as some thinking on my own, I more clearly visualized the reason why the babies were in the river in the first place, at least from my own perspective. It was now much more obvious that what I wanted to look at more closely was EBP which is the new model of treatment provision for the 21st Century. It is the way in which the Ontario government wants all mental health agencies to proceed to deliver treatment to children. This is the area I have been struggling with for the past ten or so years when it all of the sudden felt like what I was doing as a counselor was being questioned and apparently was no longer effective. Evidence, shmevidence, I started to say when this was first being discussed. I used to be questioned by superiors who I did not directly report to as to “where the evidence was in that?” when I would relay some information about what I had worked on with a child and their family. To me, the evidence was very apparent –families were happier and not arguing as much with each other anymore. I did not agree that I needed to have a program which was set up just for this case in order to do something effective for these people. I did not believe that I needed to use something that was called by a fanciful acronym in order to help families. I did not understand, once again. I was concerned about co-morbidity and

where EBP fit into children who presented with more than one diagnoses. The reason that I had wanted to look at combining an anger management program with IBT is to examine the impact of combined EBPs on children with co-morbid mental health issues. Anger management alone was not working. Perhaps the problem was that I believed that EPBs do not work with children who have more than one diagnosis.

It was Sunday afternoon – a miserable rainy, cold, day in December. I had had a meeting with my research advisor the prior week, and I had a timetable in which to complete and defend my thesis. I had wanted to graduate in June, but there was no way that this was going to happen. I had to start working and working, hard and long. I was upstairs at home, reading, and decided to go to the computer and start to write again. I asked my husband, who is relaxing, why I was doing this again, at this stage in my life. “Money,” he reminds me. “And respect, self-respect,” I added. He completed his own educational upgrading a few years ago. He could have been the help desk guy at a large company but because of pursuing higher education, he is now the manager. He wasn’t content with settling for anything less, either. So I took a deep breath, and sat down at the computer again.

Just prior to that Sunday, I was in Toronto, at a workshop for my position at work, which was put on by the people who ran and own the program we are using. It is evidence-based, and there is a great deal of money which the researchers are making as a result, from a world-wide audience. We discussed audits and fidelity checks, to ensure that we were all following the manualized program. The lead manager told us that it was like baking a cake....if you are baking your first cake ever, and decide to make substitutions before you get the foundation down pat, then you will not be successful. You need to follow the directions step by step. I struggled with this, wondering about the people who are going to eat the cake who are diabetic, or gluten-

intolerant, or have wheat allergies, and what would be done in this situation. I wondered if you keep on making the same recipe and see if respond any differently the next time? Frustration is doing the same thing over and over and expecting different results. I guess I was frustrated with the push towards EBP. I have talked to so many other therapists and counselors, who write up treatment plans with fancy methodology in the “how to” section. How do you, as a therapist, plan on helping this child with their issues. Coping Cat (Kendall & Hedtke, 2006), There’s a Volcano in my Tummy (Whitehouse & Pudney, 1997)...we have all put those fancy names in there, then proceeded to use our relationship as the crux for change. In my opinion, if you do not have a relationship, you do not have anything to base treatment on.

I wondered how I would explore my feelings and my beliefs, and then do a thematic analysis. I still wanted to interview people and learn how the day treatment staff feels about the application of EBP with the children in their classes. I, however, was not convinced that this would serve me well. I saw parallels between my pursuit of higher education and the implementation of EBPs. To me, it does not take an incredibly skilled therapist to administer the programs which are available to us all. In my opinion, it takes experience, and the ability to formulate a relationship, as well as some ways of being able to teach parents and children alternatives to their behaviours. I have no issue with running a Coping Cat (Kendall & Hedtke, 2006) group for children with anxiety disorders and I do not agree that I need a Master’s degree to do so. Perhaps it is the marginalization of professional therapists that has caused such pretention amongst Master’s people because of the implementation of EBP.

Throughout my many years of experience, I have met many wonderful children and families, with their own unique story of which I have had the privilege of hearing. This is very valuable to me, and puts me in a role which I take very seriously as I do believe that it is a

privilege, indeed. In writing this research paper, I have felt that the content can be made richer by using personal examples of my experiences I have had, but have taken a great deal of effort to conceal the identities of the people behind the stories I tell. While I make every attempt to make them real, I want to ensure that client confidentiality is noted as utmost important, so the stories which are discussed in this paper are often a compilation of several individuals, families, or incidents, that are written about in order to illustrate a point; however, names, genders, details, and other identifying factors have been changed in order to ensure the confidentiality that these people are allowed the right to. Any resemblance to a real-life incident, or person, whether living or dead, is purely coincidental.

Not that long ago, I had a phone call from a mother who had two daughters with mental health difficulties. Because of the diagnoses, I had completed some one-on-one work with one of the girls, and a colleague of mine, with a Master's, worked with the other. This girl had severe issues and could be violent and dangerous at home. The mom was very upset, as the Christmas holidays had been long and stressful, with few supports for her. As she was venting to me on the phone, she talked about how she felt that I was more experienced to deal with these issues and that she did not see how playing Snakes and Ladders for an hour every two weeks with the other daughter was being effective. It was not for me to judge, and all I could do was listen. Playing games can be effective in teaching children about fair play, team play, compromise, taking turns, and good sportsmanship. I have played games in sessions because it helps to have something for children to do to take their mind off the fact that they are talking about some truly important concerns in their lives.

I remember a family who touched me deeply with their experiences; a family with whom I worked when I was a part of the pilot project. In order to protect confidentiality, details have

been changed. Two brothers were both referred for treatment by their school, as they had had a very tragic life. Both boys were living with their aunt, since birth, and were in the young school age range of around Grade 2-4. One night while driving in the car with their aunt, the younger boy was upset about something and grabbed the wheel, causing an accident. He was able to get out of the car, his aunt was not so lucky, and she perished when the car caught fire. His brother managed to escape out the back window, on fire himself, and fell to the ground. He survived but had burns to most of his body. The brothers have since been taken in by another aunt and uncle, and are managing okay; however, they never had any counselling to deal with the tragedy.

At the time I started to work with these boys, which was a few years later, they were doing alright thanks to the love and security they were receiving from family, but there was a secret that no one had ever talked about. I was not even sure if the boy remembered that his actions caused the death of their aunt or the scars to his brother's body, which will never go away. Every day was a painful reminder for him just by seeing and interacting with his sibling. He had never spoken of what had happened, and the two fought like cats and dogs. Their aunt and uncle, as well as the school, had no idea how to help. The boys were referred to me in an anger management program and I began to work with them on getting along better. They were so wanting to tell their story and deal with what had happened that it came out little by little, every session. I was waiting for it that to occur, and had carefully planned and ensured safety for these children so that they felt okay to be able to talk about it. I set up psychological and psychiatric assessments for the youngest boy, so that we were all more equipped to deal with helping him through this horrible process.

The treatment plans were written, and the boy had set his own goal to stop fighting so much with his brother, as he pestered him all of the time. I believe that every time he looked at

him, he saw a painful reminder that he did this to him so he got on his every last nerve to help them both forget and that anger also translated into his interactions with his peers. As Method of Treatment in his treatment plan, I wrote the name of the pilot project and Cognitive-Behaviour Therapy (Sheldon, 1995). As Indicators, he had written that he will know he had accomplished this goal by getting along better with his brother, and having more friends at school. We evaluated where we were at every three months and this looked just wonderful on paper. The boy signed it and received a copy to remind him of his commitment. Nowhere on that sheet did it say anything about acknowledging and coming to terms with the fact that he caused an accident which killed his aunt and scarred his brother for life. There was not anything in his brother's treatment plan about dealing with his anger towards his brother and coming to terms with the impact his behaviour has had on him, and the rest of the family either.

My direction was to use the pilot program to wrap treatment up nicely in a package and help them deal with making pro-social choices and not ending up in jail because of their anger. I was not to deal with the trauma nor the cold harsh truth of what was driving their behaviour. I believe that anyone can teach the tools of anger management, and I struggled with how I felt boxed in to do just that. I needed to look at the impact that my experience played in this case. While I did not have a Master's degree, I do not believe that anything which I have learned as a result of taking a Master's program would have helped me with the therapeutic approach I took towards this family. I do not believe that them working with a therapist with a Master's would be exactly what the boys needed in order to move forward and have healthy, productive lives. Nor do I believe that using an anger management intervention would be the epitome of treatment. I think having a Master's degree while working with this family would serve to give credibility to my ability. I do not feel that others would or did look so highly on the twenty plus years of

experience without it, however. I was told that this is trauma, and only someone with a Master's can deal with that (Anonymous, 2010). This is a true, real life experience which I had not long ago. Again, I felt marginalized.

I felt confident in providing treatment for this family, and I know that if I did not feel and believe that I was competent and confident, I would have looked for supervision or have asked to pass the case to someone whom I believed could have been more helpful. The child had difficulty dealing with anger and he also may have some learning disabilities he was assigned to me so I could teach anger management skills. Those skills might have been helpful, but I do not believe that such skills will help him live with the fact that he caused his aunt's death and his brother to be permanently scarred. Maybe I needed a Master's in order to help this child come to terms with his situation and maybe not. I believed that if he could find someone who will talk openly, without judgment, and who is accepting of him despite his experiences, he might be able to eke out a satisfying existence. I think the relationship will be the key, and I do not think someone without experience straight from a Master's program would be the right fit.

I believed that the pilot program I worked in was like so many other cookie-cutter approaches. In reflecting on my client list, I can think of several clients, most of them in fact, that needed so much more than just that program. The single mother who had been in and out of abusive relationships, who had been beaten in front of her children, and was angry that her children were displaying aggression. This program could not change the pattern of this mother's behaviour. I think about the boy who had undiagnosed ADHD and how he would not comply at home or at school, and in taking a look at the family dynamics, it is no wonder. His father was unmotivated, made messes that he would not clean up, he did not speak to his wife or children

but to yell at them, and the ADHD boy did not just have ADHD anymore, he subsequently has an anxiety disorder.

There was another boy who had undiagnosed neurological issues from trauma at birth. I was not able to fix that one. The boy who lined everything up at home and grouped them into colours numbered everything. Yes, he was aggressive, but he was aggressive when someone disrupted his obsession.

I do not think that focusing on behaviour only will do the trick. I think behaviour is what gets these children in trouble, and an EBP such as that one looks great on paper, but in reality, is for children without co-morbidity. I do not understand why the push is for EBP, when it seems to be such a narrow field. There is a push for groups, which are more cost-effective, and both children and parents learn concurrently how to behave or how to deal with their child's behaviour, however, group therapy does not tackle the real reason behind the behaviour, such as the fact that a child's father committed suicide or is in jail for assault. This is another issue I have with some of the EBPs which are being utilized to address behaviour. We are teaching children to control their emotions, such as anger or anxiety, however, we no longer have the ability or time to address the root of the behaviour. I have experienced many occasions when the child I was working with had been traumatized in any of a number of ways, but the trauma is not addressed, nor was there opportunity to do so. Often, the number of sessions allotted for a client's diagnosis have been used up prior to having enough of a relationship, or enough of an awareness of what had occurred, to address the reason driving the behaviour.

I have been curious and perplexed about the term "EBP" for several years now. Sometimes, I think I understand what it is, and other times, I think I pretend to. I have been working in children's mental health for almost 25 years, and I think I am still pretending. After

doing a great deal of research, I believe I understand a little more; however, I am not convinced, and I also believe that I am not the only one. I have had discussions with colleagues for years, wondering “what IS EBP anyway?” I went to a one day workshop on EBP about five or so years ago that was put on by government-hires, and I walked away thinking that it is all money-based. It sounded like if you had an intervention, and conducted RCTs on it, and were able to demonstrate it to be clinically significant, you could publish it and make some money, and then they would list it as an appropriate EBP for everyone in Ontario to use and be proud of. I thought I was finally beginning to understand. While I believed I was understanding the financial aspect behind EBP, I still was interested in how it translates to children’s mental health, and was concerned about the impact of EBP on co-morbidity. While Day Treatment was an area of interest to me, I believed that this was too narrow and wanted to look at EBP within children’s mental health as a whole.

First, I want to understand what exactly EBP is. I have always viewed it as a cookie-cutter approach to treatment. I have read articles on EBP and hand washing, and how it has been statistically proven to decrease the spread of infection, which is an easy and simple example. I’ve looked at the impact of a long-term EBP with regards to treating people who are infected with HIV. These are both medical scenarios, which is the root in which EBP is derived.

In the last ten or so years, the push for EBP has been everywhere. There has been a great deal of debate over the translation of RCTs and the movement to EBP in practice. Some people do not agree that it is appropriate in the field of children’s mental health or social work in general, that it is too clinical and does not account for the relationship. I maintain this concern; that anyone can apply a cookie-cutter recipe to a diagnosis, but what about the “person” who is diagnosed? Where does that fit in? Is the art of relationship building lost? Is it being phased

out? I like to compare EBP with the necessity for someone like me, with 23 years of experience, and an Honours BA in psychology, needing to go back to school to get a Master's. I wonder if the lack of a Master's degree negate the 23 years I have spent at the same agency, learning tools which are prescribed, implementing them, and seeing some pretty positive results. I wonder if attaining a Master's will allow me to become better at implementing EBPs. I know many professionals with whom I work who do not understand EBP. I am unsure of the difference between the manualized interventions I am supposed to be utilizing and the other treatment modalities that I am well-schooled in and have been practicing all along. I wonder about eclectic therapies which seem to have a bigger impact on children, particularly those with co-morbid mental health issues. If those are being perceived as no longer working, I wonder about the reasoning behind this. The EBPs that are getting funded are those which target only one set of issues. I am curious as to why I have not been given this information before and why am I needing to discover it for myself. I am concerned whether the dissemination of knowledge is the problem or whether this is it just my own issue.

I am interested in the theory behind EBP, and after much reading and research, it appears to me that there is an eclectic approach to the theory. It appears that much of the practical, manualized interventions, are founded in Social Learning Theory, developed by Bandura (2001). Other practices such as Solution-Focused Therapy (Berg, 2004) seem to be based more on Systems Theory (Shellenberger & Hoffman, 1995). I will look at EBP through the lens of Foucault (1991) and will pursue the following question: Can EBP be effective in children with mental health issues, including co-morbid mental health issues? Is it cost-effective, which is the root of utilizing EBP in the first place? Is there a difference between the different types of EBPs

which are utilized? This will be an auto ethnographic study based on my experiences and own feelings around this issue.

I remember having a discussion with another professor around the interpretation of use of EBP. I really liked the way she thought, and the directionality of her belief. She told me that EBP should be viewed as the starting place for treatment, as a guide for what to provide to children and their families. This makes perfect sense to me. I am not sure that this is the way in which most people I work with view it, or is it the way that the funders view it.

How do we define evidence? I believe this question needs to be answered before I can move on with this. I think the majority of researchers want to look at moving social work into something more scientifically oriented. We, who provide some sort of therapy, have been conducting treatment one way for so long, and now governing bodies want us to show that it, in fact works. How do we know if what we have been doing is not causing more harm than good? We have always taken a proactive approach to treatment, looking at treatment plans and goal areas and indicators, and using these indicators to determine if one has reached a goal area, and if so, then the client is discharged. There has not been a great deal of research in longitudinal studies based on this treatment modality. I remember very clearly having heard and saying to myself that we have now given our clients the tools to use, it is up to them to decide if they want to use them or not. In Outreach Services, we would conduct follow-up for a year –which made a lot of sense– providing booster shot sessions to remind families to get back on track or keep on track, and those were pretty positive meetings, a lot of the time. We do not always do that as general practice. I do not think we do, nor do I think we can, given the limitations of time and money. Would it be more helpful if we did this as a rule? Probably. Do we always care? Sometimes.

One day in the not-so-distant past, I was talking with one of my young colleagues, who was incredibly upset because she worried that meeting with her client may increase her suicidal ideations and gestures, and she was immobilized to the point of crying, feeling so badly that she was going to make things worse. I gave her some input and talked about making sure she was taking care of logistics and liabilities in terms of ensuring that Children's Aid was aware of her concerns for this child, and I think she thought I was being glib. While I was concerned about her and the relationship which she and this child will develop, I was able to keep it at the door when I left that night. She said she would not be able to sleep all weekend. Does this make me a cold and callous therapist? I am not sure. I certainly remember being in those shoes twenty or so years ago, where fellow colleagues and I would go out for coffee after an afternoon shift and process the events of the evening for hours on end, then get up and go right back at it the next day. Is residential work different because of the day-to-day component? Is it more difficult to drop your feelings at the door because you live, eat, and breathe with these mentally ill children? Is the relationship important or is the fact that you play "The Thinking, Feeling and Doing Game" (Gardner, 1973) with the children being the most important factor. Would I have been as effective as a counsellor as I thought I was if I was not so invested? Or would I be more effective if I was not as invested? Again, I am not sure. If I have a Master's will I truly be above all of that? Or is it time and experience which makes me above all that? I do not know.

If I do just EBP with clients does that make me above all that? If I use my relationship and use it professionally, does that make me above all that? Or is it a combination of relationship, experience, and EBP? If that is the case, which one comes first? The EBP, the relationship, or the experience? The colleague I just mentioned was a young, Registered Social Worker, with little experience in dealing with children and was administering our EBP model to

a suicidal girl. She had only seen the child once and would doubt that there has been much of a chance for the relationship to form at that point. I would argue that the EBP will not go very far without the development of the other two components - relationship and experience. I did not think she would get very far by focusing on anything other than the relationship as the client needed to learn to trust and feel safe. After this, any EBP might be effective; however, if the Social Worker did not grow with the relationship and with the experience, I was not clear on how long it would last, how effective it would be, and how long the Social Worker would be able to continue in this line of work.

I had a case passed to me, by a Registered Social Worker, because she did not believe that she had the experience to help them grow any further. Interestingly enough, the mom and child were devastated by this switch, because the clients had developed a good strong positive relationship with the previous worker and consequentially took some time to warm up to me. Did experience or EBP help with having them work on some of their issues in this case? I do not believe so. It was pure relationship building. I had to work even harder at building a relationship with these people than I usually do because of that experience with someone else.

When I was completing my undergraduate degree in psychology, so many years ago, I was heavily influenced by Carl Rogers (1958). I liked his approach to humanistic psychotherapy and his work in empathy and unconditional positive regard. I'm still influenced by it and I think this theory sticks out in my mind because a few of my professors back then were heavily influenced by it too. I am unsure if this approach is still taught. I also wonder how much emphasis and effort is put into the concept of EBP in undergraduate and graduate school these days. I find that in the particular program which I am taking, there is a lot of interest and a lot of talk regarding the concept, and that many people have different opinions. I have had

conversations with some of my younger colleagues who have said that their classes barely touched on the concept, other than that it was based on randomized control studies and little more than that. Now, whether this is the case or they simply forgot about it because it was not important to them at the time I am not sure. I am very interested in this.

In the survey which I put out to fellow practitioners, I asked about the actual practice of EBP in their work. I wanted to determine if anyone said that they use a specific intervention in their treatment plan because this is what is expected, but found it challenging to incorporate it into actual treatment. It was not my intention to police what my peers are doing, but rather, to determine if indeed this shift is actually occurring as it was expected to. I am not convinced that naivety around EBP is entirely restricted to me, and I can see that people might be inclined to deny this as something my peers have successfully managed to perform in their work. Gambrill (2006) had the same concern, questioning what view staff would take with regards to implementing EBP. Would practitioners use the name but not the substance, and continue business as usual? This is, in my opinion, different than “mailing it in,” or going through the motions. If this does occur, I think it is because of the sheer complexity of the notion of EBP which cannot, in my experience, be neatly packaged and distributed. I do not believe there is anyone or thing to blame for this. I believe that we all have different understandings of what EBP is and think that if the literature is confusing about this notion, it is reasonable to expect that the dissemination is confusing as well.

As I began my research, I needed to see what was out there in terms of other people’s experience with EBP and what it means to the rest of the world in terms of children’s mental health. I was at an Annual General Staff Meeting for our agency a few years ago and we had a keynote speaker, who is very prominent in children’s mental health in Ontario. I remember he

ended his speech with something to the effect of “we, as a whole are not providing children with the proper treatment by use of EBP....shame on us.” That was profound for me because I did not really understand what this meant. I still do not.

Chapter 5: Survey Results

I was certain that I was not alone in my understanding of the implementation of EBPs in children's mental health. I wanted to determine if other front-line staff working in children's mental health had the same, similar, or even opposite experiences. I designed and conducted a twenty question online survey for front-line staff (see Appendix I). One hundred surveys were emailed to full-time employees of a Children's Mental Health agency in Ontario, through the agency's employee email list. The participants had 4 weeks to complete the survey, at which point they were notified that it was closing. Invitees included managers as well as staff, limited to those who wrote treatment plans or supervised those who wrote treatment plans. Of those 100 surveys which were sent, 22 individuals completed them. One needed to be omitted as it was spoiled. Several people (approximately 7) indicated that they would not complete the survey with no further explanation. Participants had been informed that a report would be written afterwards so that everyone would see the results of this survey. Some participants expressed concern that this report was to be shared with the staff and management. Their concerns seemed to be focused on management having access to the report but none of them explained the nature of their concerns. This could be interpreted as concern about an ulterior motive behind the survey or that management might use it to determine knowledge and skill level of the staff, for employment reasons rather than for research for a Master's thesis.

The survey included nineteen questions associated with various aspects of EBP or related concepts, and a final question about the length of time the individual had worked at the agency for which they were currently employed. The questions all drew upon personal experience with EBP, and also asked for the respondents' understanding of the definition of EBP, as well as EBT, and EIP. I thought that it was necessary to explore how respondents distinguished between these

definitions. Other questions focused on participants' knowledge and use of EBP and examined areas such as training in EBP through formal education, discussion of how equipped they felt in using EBP, effectiveness of EBP in their work; discussion of EBP with management personnel, use of EBP in treatment plans, and the use of EPB with clients who have multiple diagnoses. The survey included a mix of open ended questions and questions which used a ten-point Likert scale.

Participants were provided with a deadline for completing the survey. Once this deadline had been reached, I closed the on-line survey and began to compile the responses. As previously mentioned, the surveys were administered on-line and were fully anonymous as no identifying information was collected through the survey questions and the survey website did not track or record e-mail or IP addresses. The open-ended questions were compiled by question across participants and subjected to a thematic analysis. Those questions which prompted a response on the ten-point-Likert scale are reported in a table of means (see Table 5.3) and I also conducted a correlational analysis (see Tables 5.1 and 5.2) . Responses to the open-ended questions will be reviewed first followed by the descriptive statistics and the correlations.

Table 5. 1 Correlational Table Illustrating Pearson Correlation, Significance and Total Number of Responses

	Q # 4	Q # 5	Q # 6	Q # 8	Q # 9	Q # 11	Q # 12	Q # 13	Q # 14	Q # 15	Q # 16	Q # 19	Q # 20
Q # 4													
r	1.00	.28	-.07	.40	.05	.45*	.34	.42	-.33	.16	.28	.09	-.30
Sig	.23	.23	.77	.07	.85	.04	.13	.06	.15	.49	.22	.69	.19
N	21	21	21	21	21	21	21	21	21	21	21	21	21
Q # 5													
r	.28	1.00	.42	.73**	.09	.15	.67**	.59**	-.75**	-.26	.61**	.15	-.24
Sig	.23		.06	.00	.69	.33	.001	.005	.00	.26	.004	.51	.30
N	21	21	21	21	21	21	21	21	21	21	21	21	21
Q # 6													
r	-.07	.42	1.00	.23	.09	.23	.09	.39	-.72**	-.32	.47*	.44*	-.44*
Sig	.77	.06		.31	.69	.33	.70	.08	.00	.16	.03	.05	.05
N	21	21	21	21	21	21	21	21	21	21	21	21	21
Q # 8													
r	.40	.73**	.23	1.00	.04	-.07	.50*	.42	-.54*	-.17	.35	-.40	-.08
Sig	.07	.00	.31		.87	.76	.02	.06	.01	.46	.13	.88	.73
N	21	21	21	21	21	21	21	21	21	21	21	21	21
Q # 9													
r	.05	.09	.09	.04	1.00	.12	.16	-.06	.08	-.17	.08	-.29	-.34
Sig	.85	.71	.69	.87		.60	.49	.79	.74	.46	.74	.20	.13
N	21	21	21	21	21	21	21	21	21	21	21	21	21
Q # 11													
r	.45*	.15	.23	-.07	.12	1.00	.35	.45*	-.23	-.32	.31	.34	-.12
Sig	.04	.52	.33	.76	.60		.12	.04	.32	.15	.18	.13	.61
N	21	21	21	21	21	21	21	21	21	21	21	21	21
Q # 12													
r	.34	.67**	.09	.50*	.15	.35	1.00	.32	-.36	-.15	.33	.16	-.03
Sig	.13	.001	.70	.22	.49	.12		.16	.11	.52	.14	.50	.91
N	21	21	21	21	21	21	21	21	21	21	21	21	21
Q # 13													
r	.42	.59**	.39	.42	-.06	.45*	.32	1.00	-.61**	-.26	.40	.29	-.18
Sig	.06	.005	.08	.06	.79	.04	.16		.003	.25	.02	.20	.45
N	21	21	21	21	21	21	21	21	21	21	21	21	21
Q # 14													
r	-.33	-.75**	-.72**	-.54*	.08	-.23	-.36	-.61**	1.00	.19	-.66**	-.50*	.49*
Sig	.06	.00	.00	.01	.74	.32	.11	.003		.42	.001	.02	.02
N	21	21	21	21	21	21	21	21	21	21	21	21	21
Q # 15													
r	.16	-.26	-.32	.17	-.17	-.32	-.15	-.26	.19	1.00	.39	-.50*	.49
Sig	.49	.25	.16	.46	.46	.15	.52	.25	.42		.09	.02	.02
N	21	21	21	21	21	21	21	21	21	21	21	21	21
Q # 16													
r	.28	.61**	.47*	.35	.08	.31	.33	.40	-.67**	-.39	1.00	.31	-.40
Sig	.22	.004	.03	.13	.74	.18	.14	.08	.001	.09		.17	.10
N	21	21	21	21	21	21	21	21	21	21	21	21	21
Q # 19													
r	.09	.15	.44*	-.04	-.29	.34	.16	.29	-.50*	-.82	.31	1.00	-.25
Sig	.69	.51	.05	.88	.20	.13	.50	.20	.02	.72	.17		.28
N	21	21	21	21	21	21	21	21	21	21	21	21	21
Q # 20													
r	-.30	-.24	-.44*	-.08	-.34	-.19	-.03	-.18	.49*	.24	-.37	-.25	1.00
Sig	.20	.30	.05	.73	.13	.61	.91	.45	.02	.29	1.00	.28	
N	21	21	21	21	21	21	21	21	21	21	21	21	21

*Correlation is significant at the 0.05 level (2-tailed)

** Correlation is significant at the 0.01 level (2-tailed)

Please refer to Appendix 1 for full questions in survey.

Table 5.2. Significant Correlations

	(5) How equipped do you feel you are to use EBP in your work with clients?	(6) How much do you feel EBP contributes to the effectiveness of your work?	(8) How confident are you in your understanding of EBPs?	(12) How likely are you to ask a manager for more information on EBP?	(13) Would you say you are nervous to ask for more information on EBP because you think you <i>should</i> know what it is?	(14) Do you worry that you will be “caught” not using EBP because you are not exactly sure what it is?	(16) Have you ever written an Evidence Based Treatment (EBT) into your treatment plan without actually intending to use it?
(5) How equipped do you feel you are to use EBP in your work with clients?			$r = .73$	$r = .67$	$r = .59$	$r = -.75$	$r = .61$
(6) How much do you feel EBP contributes to the effectiveness of your work?					$r = -.72$		
(8) How much do you feel EBP contributes to the effectiveness of your work?	$r = .73$						
(12) How likely are you to ask a manager for more information on EBP?	$r = .67$						
(13) Would you say you are nervous to ask for more information on EBP because you think you <i>should</i> know what it is?	$r = .59$					$r = -.61$	
(14) Do you worry that you will be “caught” not using EBP because you are not exactly sure what it is?	$r = -.75$				$r = -.61$		$r = -.66$
(16) Have you ever written an Evidence Based Treatment (EBT) into your treatment plan without actually intending to use it?	$r = .61$					$r = -.66$	

The thematic analysis examined themes within and across questions. The first three questions in the survey asked participants to provide definitions of EBP, EBT, and EIP. It was clear from the responses to these questions that while some individuals had clear definitions for each of the terms, more individuals seems to have some level of confusion between the various definitions and the distinctions between them. Sixteen people offered clear definitions for EBP as demonstrated by the definition (see below) offered by one participant:

“It is an approach used in numerous fields. The primary tenets are that decisions regarding treatment interventions should be predicated upon research studies that can be replicated. Decisions about how to provide care or service and to what extent is decided by integrating the best available evidence with practitioner expertise and other resources, and with the characteristics, state, needs, values and preferences of those who will be affected.”

It was also interesting to note that two individuals offered definitions combined with personal evaluations. For example, one participant was clearly questioning how EBP operated in her comment, and suggested that it would be more easily to accept new practices if there were more “...accredited, formal and acceptable research to support a particular practice, strategy or technique which will produce a predictable outcome. My challenge is who is charged with the decision making power on what is... acceptable and what is not.” Other responses provided clear evidence that some participants found EBPs limiting and questioned the validity of the supporting research. For example, one participant stated “Personally I believe that they can be a bit limiting, and studies usually focus on specific issues and do not allow for enough blending or holistic approaches.”

The confusion among the three terms (EBP, EBT, EIP) became evident when examining the responses provided to the questions about defining EBT and EIP. Nine participants knew the difference between treatment and practice as indicated by the following response about EBT, “EBT would be using a specific therapeutic program rather than just a model (i.e. using

Incredible Years rather than just using a CBT model).” while ten were unclear of the difference between the two, “I never thought of these as separate concepts, I would think EBT is treatment based on research.” This was similar to the pattern of responses offered on EIP in which some respondents had clear definitions such as, “In my opinion, is a better practice, takes a more holistic approach, allows practitioners to use logical parts of proven research and techniques that may apply to or meet a client’s needs, and blend it with other tools.” while others seemed less clear “A practice that is based on research that stems from EBP, however there is no direct research on one specific practice being used.”

In Question 7, participants were asked to clarify how EBPs contributed or did not contribute to the effectiveness of their work. The responses varied but the majority (13) indicated that there were some benefits associated with EBPs. As one respondent stated, “It is good to know that what you are doing with a client has been proven to work.” Five other respondents indicated that the rigidity of some EBPs was not helpful in actual practice. As one participant indicated, “EBP provides guidelines for treatment, however these can be modified to best accommodate the clients (i.e. incorporating art activities as part of a CBT approach for clients who are younger, or unable to be engaged through paper and pencil worksheets)” while another suggested that “EBP is a great guide to use especially with unique populations (e.g. ERP-CBT with OCD clients), however EBP always needs to be modified or adapted to serve these populations”. I wish to highlight the following response: in that one person argued that the move towards EIP would be more effective, as opposed to utilizing manualized treatment interventions.

“Research provides amazing breakthroughs and tools, past practice also gives good guidelines, but theories can always be proved or disproved depending on circumstances or interpretations. Knowledge should always be ongoing and expanded, and I support

a shift away from the rigid EBP and EBT and would like to see thing move in the direction of more evidence informed work, allowing for more flexibility, meeting client needs, respecting skills, and the square peg round hole phenom.”

When asked in Question 10 what sort of training might be helpful, there were varying degrees of the kind of training people were interested in and how they believed that training should be organized and provided. For example, one respondent suggested that “Training into EBP that can be adapted to meet the needs of the clients (but still remain valid and reliable).” while another questioned the process and regulation, “When there is a governing body that regulates EBP and certifies these practices training in this might be more accepted and trusted.” Responses to this question had the most variation as individuals were interested in a wide range of training options. The theme which ran through this question was the implied agreement that additional training of some type was needed.

Respondents were asked in Question 17 if they thought that clients who are experiencing co-morbid mental health symptoms could be effectively treated using EBP interventions. The responses to this question were mixed. Ten felt that EBPs could be effective for clients with more than one diagnosis, while eight responded that they were not confident that this could be the case. One respondent indicated that, “I think if you focus on the symptoms yes. Focus on particular symptom and treat them with EBP and then move on to the next set of symptoms.” while another expressed more concerns, “holding steadfast to EBPs as the only method to use will disengage some clients and also promote the idea that ... problems can be solved or "cured" in 8-10 sessions - not true at all and misleading for the clients.” A third respondent also had concerns but seemed more optimistic as reflected below.

“I think there are many interventions out there so it's a matter of finding the right one for each client. Determining what to treat first is often up to clinical knowledge and comfort of the therapist. Research is not as good at determining a one size fits all approach to

children but I feel that they will eventually tease these intricacies out with further studies that extend beyond the lab.”

When asked in Question 18 to provide more clarity on their responses about co-morbidity and EBP, nine people chose not to respond while eleven provided very detailed responses. Six individuals were confident that EBP was the right direction and would help clients, “EBP provides not just the direction but the reason for taking that route. That understanding provides a confident structure to begin treatment.” Others indicated more reservations, “I believe that there is a danger to using a "one size fits all" approach to working with clients.” Seven respondents focused on the client stating, “ Sometimes one cluster of symptoms needs to be addressed prior to or in combination with another...The best treatment direction for this client may involve one EBT for Anxiety and Depression in conjunction with another that better suits BPD.”, “Depending on the diagnosis and the presenting needs of the client symptoms may need different approaches and timing is everything”, and “I prefer to address each client individually based on their needs, strengths and diagnosis. Co-morbidity continues to be widely researched, interventions shown to be effective are always beneficial for a clinician to consider.” One respondent was concerned about the motivations behind the push towards EBP and how the clients were considered or not considered in that movement.

“Unfortunately the ministry people making decisions have little to no clinical background - when they see that a problem can be cured in 8-12 or whatever sessions as promised by most EBPs, what they see is that we can see more people and "cure" more problems in less time and thus for less money - they then make asinine recommendations or ideas for spending budgets that have nothing to do with client centred approaches that they also preach.”

The concerns which were expressed within the open response questions were also present in the responses to the Likert scale questions. Table 5.1 shows the mean response for each of the Likert scale questions broken down according to the number of years worked at the agency.

There are a few items of interest to note when reviewing the table. When asked about knowledge of EBP from formal education, the mean scores were highest for those who had been at the agency for 2.5 years or less and lowest for those who had been at the agency for fifteen years or more. Accordingly, individuals varied in terms of how equipped they were to use EBP with the highest means associated with individuals who had been with the agency for two to fifteen years. In terms of the effectiveness of EBP, the lowest mean was associated with individuals who had worked at the agency for over fifteen years with the other means being very similar. While responses varied to this question, the majority indicated that there were some benefits associated with EBPs and only one person one person did not agree that it was effective at all.

Table 5.3 Survey Score Mean by Years Worked

Question	Mean	Years at Agency
4. How much did you learn about EBP with regards to children's mental health, when you completed your formal education?	2.5 (n= 3)	16+
	4.43 (n= 6)	11-15
	4.5 (n=2)	6-10
	6.0 (n= 8)	2-5
	6.0 (n=2)	Less than 2 years
5. How equipped do you feel you are to use EBP in your work with clients?	3.0 (n= 3)	16+
	8.57 (n= 6)	11-15
	8 (n=2)	6-10
	7.57 (n= 8)	2-5
	6 (n= 2)	Less than 2 years
6. How much do you feel EBP contributes to the effectiveness of your work?	4.0 (n=3)	16+
	6.86 (n= 6)	11-15
	8.0 (n= 2)	6-10
	7.0 (n=8)	2-5
	7.5 (n= 2)	Less than 2 years
8. How confident are you in your understanding of EBP?	5.5 (n=3)	16+
	7.57 (n=6)	11-15
	8.0 (n=2)	6-10
	7.57 (n=8)	2-5
	5.5 (n=2)	Less than 2 years
9. Do you feel that you need more training in EBP?	4.5 (n=3)	16+
	3.43 (n=6)	11-15
	6.5 (n=2)	6-10
	5.0 (n=8)	2-5
	5.5 (n= 2)	Less than 2 years
11. How likely are you to ask peers for more information on EBP?	4.0 (n=3)	16+
	6.86 (n=6)	11-15
	4.5 (n=2)	6-10
	7.29 (n= 8)	2-5
	5.0 (n= 2)	Less than 2 years
12. How likely are you to ask a manager for more information on EBP?	3.0 (n= 3)	16+
	6.14 (n=6)	11-15
	1.0 (n= 2)	6-10
	6.0 (n=8)	2-5
	3.5 (n= 2)	Less than 2 years
13. Would you say you are nervous to ask for more information on EBP because you think you <i>should</i> know what it is?	5.0 (n=3)	16+
	8.14 (n=6)	11-15
	9.0 (n=2)	6-10
	8.43 (n= 8)	2-5
	5.5 (n= 2)	Less than 2 years
14. Do you worry that you will be "caught" not using EBP because you aren't exactly sure what it is?	6.5 (n=6)	16+
	2.14 (n= 6)	11-15
	2.5 (n= 2)	6-10
	2.0 (n=8)	2-5
	2.0 (n=2)	Less than 2 years
15. Have you ever written an Evidence Based Treatment (EBT) intervention into your treatment plan and then found that you didn't actually use it?	7.5 (n=3)	16+
	6.43 (n=6)	11-15
	5.0 (n=2)	6-10
	6.14 (n=8)	2-5
	7.0 (n=2)	Less than 2 years
16. Have you ever written an Evidence Based Treatment (EBT) into your treatment plan without actually intending to use it because you did not think it would be beneficial, but you felt you needed to write something supporting this anyway?	3.0 (n=3)	16+
	7.43 (n=6)	11-15
	8.5 (n=2)	6-10
	6.71 (n=8)	2-5
	8.5 (n=2)	Less than 2 years
19. To what extent do you agree with the shift to EBP in social services?	3.0 (n=3)	16+
	6.86 (n=6)	11-15
	3.0 (n=2)	6-10
	7.14 (n=8)	2-5
	7.0 (n= 2)	Less than 2 years

In terms of confidence in using EBP, the means were lowest for those who had been with the agency for over fifteen years or less than two years. All groups agreed that more training was needed, although the strength of the agreement varied. The means varied with no clear patterns when respondents were asked to indicate how willing they were to ask peers (question 11) or a manager (question 12) for more information on EBP. Interestingly, high means for individuals who had been with the agency for two to fifteen years indicated that they were nervous to ask about EBP because they felt they should know what it is. In contrast, only those who had been with the agency more than fifteen years indicated a concern about being “caught” not using EBP due to lack of knowledge. The means of all groups suggested that they had written EBT into a treatment plan and then found they did not use it in treatment. The means of many of the groups also indicated that they had written EBT into a treatment plan without intending to use it. Those who had been at the agency for more the fifteen years had were the least likely write an EBT into the treatment plan with no intention of using it. The responses to the question about the shift to EBP in social services are not adequately captured by the means. The individual response were quite diverse: five respondents agreed a great deal; four indicated EBP is a better way of doing business; two agreed with the shift to a certain extent; seven agreed somewhat, believing that we all have to show that we are accountable; four people did not agree at all, claiming that the people making these changes do not understand front line work.

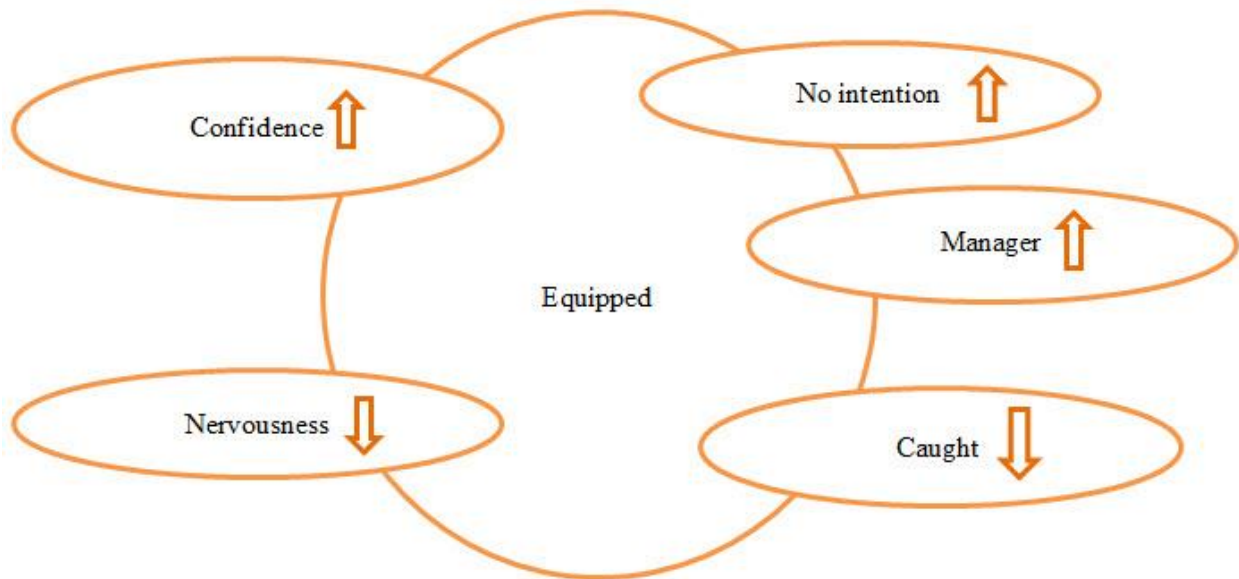
Given that the mean responses were interesting and a few patterns emerged, I was intrigued to see if there were any correlations between the items. When reviewing the results, I decided only to discuss those correlations which were significant at the $p \leq 0.01$ level given the small sample size. There were correlations which are suggestive, in a few areas, mostly pertaining to feeling equipped and regarding worries of being caught. Feeling equipped to use

EBPs in their work with clients was the strongest indicator of confidence level in implementing EBPs ($r = .73$) and not feeling nervous about asking for more information ($r = .59$). Participants who did not feel properly equipped to use EBPs also did not seek out more information from their manager ($r = .67$). Those respondents who felt equipped enough to use EBPs also were not concerned about being ‘caught’ not using them ($r = .08$). Those participants who felt equipped also did not write EBPs into treatment plans without the intention of ever using them ($r = .61$). There was also a converse relationship between those who did not feel equipped to use EBPs in their practice, and those who felt less confident in implementing EBPs. Those who felt less equipped also felt more nervous about asking for further information and were more concerned about being ‘caught’ not using them. They were more inclined to write an EBP into their treatment plan without any intention of using them and less likely to seek out management support.

Scores on the question about worrying about being ‘caught’ not using EBPs were also interesting. Those participants who indicated that they were concerned about being ‘caught’, felt more nervous about asking for more information ($r = .61$) because they felt that they should know more. Those respondents also worried about being ‘caught’ and agreed that they had written EBPs into their treatment plans without the intention of using them ($r = .66$), because they felt that they should include them. Similarly, some respondents felt that EBPs do not contribute to the effectiveness of their work with clients ($r = .75$) and as such, felt concern about being ‘caught’ not using EBPs. There was also a converse relationship in that those respondents who were not worried about being ‘caught’ did not feel nervous to ask for more information, and did not write EBPs into their treatment plans without the intention of using them. Those respondents also felt that EBPs contributed to the effectiveness of their work with clients and

therefore did not feel worried about being ‘caught’ not using them. Figure 5.1 provides a visual demonstration of the correlations between feeling equipped, and confidence level, nervousness, worry about being caught, having no intention of using EBPs despite writing them into treatment plans, and whether or not that person would seek out information from a manager.

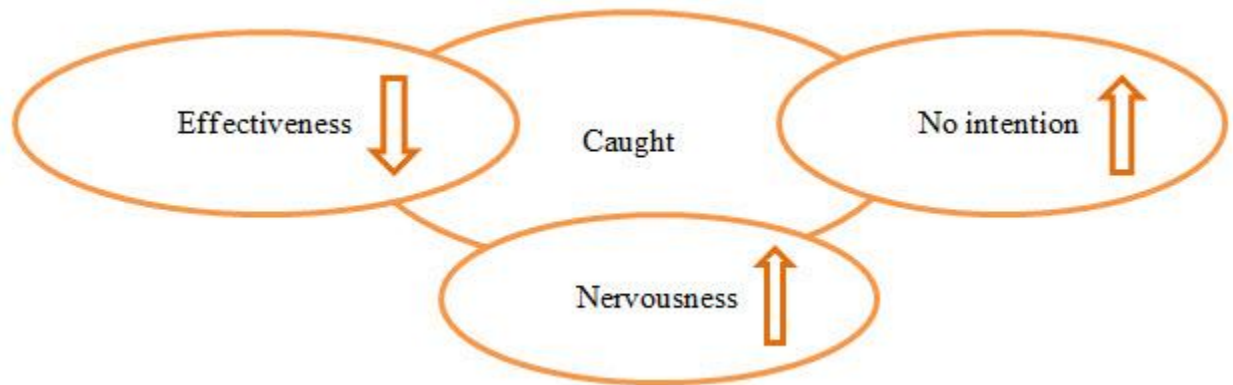
Figure 5. 1. Correlational diagram of participants who feel equipped to use EBPs and associated correlations



Taken in its entirety, the following correlations speak to the need for more training to help ensure that clinicians feel more equipped to use EBPs in their practice, and at the same time, speaks of how those practitioners who do use EBPs and are comfortable with them, feel that EBPs are helpful and add to the effectiveness of treatment. It is quite evident that there needs to be more dialogue on all levels to ensure that practitioners feel comfortable enough to ask questions without the fear of reprisal. Figure 5.2 provides a visual demonstration regarding the correlation between fear of being caught, belief in the effectiveness of EBP; feeling nervous to

ask for more information; and writing EBPs into a treatment plan without the intention of using them.

Figure 5.2 Correlational diagram of participants exhibiting worries of being “caught” not using EBPs and associated correlations



Chapter Six: Autoethnography

In this chapter, I examine the themes which have become evident after comparing my experiences with those of my colleagues, and contextualize those themes within the literature. I then offer my reflections on the role of EBP in children's mental health with a particular focus on children with co-morbid mental health diagnoses, as well as conclusions and implications for the field of children's mental health. I also discuss the parallels between the implementation of EBP and the necessity of my return to graduate school, to pursue a Master's degree. I then close with recommendations for the funders of children's mental health for future research.

Themes

Many of the findings in my autoethnography and the survey were very similar to the literature on EBPs. There were also some connections involving very common themes which came to light. While many themes became apparent, there are some which seem more prominent than others, which also act as a starting point to explore some of the deeper issues. Over-riding themes which emerged are as follows: the tension among education, experience, and respect; the tension between the top-down implementation of EBPs versus bottom-up implementation; the need for training; relationships; and the "elephant in the room" which exists with regard to both practice and clinical level and specific to the discussion of EBP." Intertwined throughout is the concept of resistance. These themes will be contextualized through the lens of Foucault.

Education, Experience, and Respect

There is a great deal of tension which exists among elements of education, experience, and respect. This has been clear throughout my autobiography and through my decision, after more than twenty-two years in children's mental health, to return to university to pursue a graduate degree. This continues to hold true in my recent experiences. After working in a pilot

project for over two years, in which I administered a manualized EBP to children and spent a great deal of time collecting data, I had the opportunity to apply for one of several Master's level positions which were posted at the agency I work for. I was unsure if I would be allowed to apply because I had not yet finished my graduate degree; however, I was able to do so. I went through a very rigorous interview process and was granted a position as a Therapist in Brief, Solution-Focused Therapy (Berg, 1994). An evidence-based, but not manualized service.

In my autobiography, I spoke of the ambivalence and lack of confidence in myself both as a therapist and as a graduate student. I believe a lot of this was because of my own self-perception, as opposed to those perceptions by other people. While I felt disrespected because I did not have a Master's degree, I am now able to see that this was my own issue and I have come to terms with this. I have compassion for some of my colleagues, many of whom are younger and have an undergraduate degree, and who are experiencing the same emotions and trepidation which I have experienced many times. Some are pursuing their Master's, because they would like to make more out of their career than what they are told they are capable of, or allowed to do, with the degree(s) that they possess. I have heard many of them say "I know I can do it, I don't know why the agency won't just give me a chance," when they want to apply for a Master's position, or Clinician II, as those positions are called. I have flashbacks, as it was not that long ago when I shared this experience. In the past, I may have cheered them on to rage against the machine; however, the older and wiser me offers them encouragement to return to school and get that degree.

In looking back on my career, I am attempting to determine at what point the emphasis on education emerged, an emphasis which was not prominent when I began working within children's mental health. While there was a hierarchy, in which front-line work such as

residential or day treatment positions were at the bottom, there seemed to be a blurring which occurred, particularly if you were well-liked by the management in the agency you worked for, or if you were viewed as a “yes-man.” I remember people who did not have an undergraduate university degree, let alone a graduate degree, moving up in the ranks because those people were liked or because they did what they were asked to, without argument or question. Some people were able to do this because of their strong personality, which did not necessarily mean that they were well liked. I recall when it became fiscally necessary for agencies to start amalgamating with one another throughout the province, when smaller agencies which were perceived as being more “family-oriented” were turned into larger, more corporate organizations. Because two or more agencies were being blended into one, managers were eliminated as the number of them was no longer necessary. It seemed to become a survival of the fittest, in that those with the most experience, seniority, and educational qualifications were the managers who remained. This shift seemed to occur around the same time when educational requirements changed. Foucault would define this in terms of the concept of governmentality (Foucault, 1991) in that there was a movement to develop further control over various institutions including social services. The link between governmental financial restraint, the shift to utilizing EBPs in children’s mental health; and the heightening of educational requirements does not seem to be coincidental at all. This has also been demonstrated in the literature review, whereby the movement of social work from an art to a science has been well-documented over the past two decades or so (Humphries, 2003; Matthew et al., 2003; Gambrill, 2006; Blom, 2009; Beddoe, 2010).

In terms of looking at my research through the lens of Foucault, much of what he theorized and how others have interpreted his work (Freshwater & Rolfe, 2004; Griffiths, 2005; Holmes, Murray, Perron & Rail, 2006; Mantzoukas, 2008) supports both my perceptions and

experiences, and those of my colleagues. The concept of governmentality speaks to the experiences that both professionals and clients in children's mental health are undergoing. Given that governmentality refers all of the action plans, or agendas, reflections and actions that seek to drive the behaviour of others (Foucault, 1991), there is no question that EBPs fit into this category. EBP has come to be a current 'regime of truth' which has been implemented and imposed on our current culture and is enforced and regulated by the discipline. As mental health practitioners, professionals are definitely under the 'gaze' of the panopticon as are our clients, who are being monitored on several levels – from clinician, to manager, to various levels of government.

Foucault (1970) believed that human sciences were consistently simplifying themselves, and sensed that they were too imprecise and too relative. While he was not in favour of the concept of science as a whole, he actually stated that he did not believe that human science should be considered a science at all, rather more of what he referred to as a "dubious discipline" (Gutting, 1989), as it did not meet the criteria for any scientific form of knowledge. The concept of children's mental health not being an exact science strikes me on several levels, both personally and professionally. This was most striking for me when I perceived that I was being marginalized because of the lack of a Master's degree. I questioned the necessity of engaging in further education, mostly because I believed experience should have been taken into account and treated as a relative equal to having a graduate degree. Foucault's belief that human sciences should not be perceived as a science could be viewed as supporting my theorizing.

I question why further education would be necessary if it is viewed as dubious in terms of being a discipline. In looking at it in this regard, further education could be viewed as being quite ineffective. When the notion of social sciences is discounted from a philosophical point of view,

it is easy to feel marginalized regardless of the level of education one has. Despite this, there is always judgement by some people and some professions, and perceptions can be skewed based on the level of education arrogance one has. Foucault (1998) would refer to this as the concept of power and the fact that “power is everywhere and comes from everywhere; it is something that is in steady flux and constantly in the process of negotiation” (p. 63). While this is prevalent in most professions, in my experience, it has increased in children’s mental health over the last few years with the push towards EBP. This has coincidentally or not, occurred at the same time when academic designations have become more relevant than experience alone. Along with other people, I have resisted the push to attain a Master’s degree, and because of the economic climate, it is doubtful that the expectation to have a Master’s degree will change in the near future; that is, until there is shortage in employees who are willing to do this type of work.

In the past several years, since my move from the position of Residential Family Worker, I have spoken with many different residential workers. Discussions have centred around how there used to be a Family Worker dedicated solely to residential treatment, and others argue that this worked well. Some of the newer staff members asked about changes which have occurred over the years and why, if it worked so well, had it changed. Many of the more experienced staff explained that they were told that the movement occurred because ‘it was not Evidence-Based,’ which is what managers told the staff when they have asked to return to that model. There is still a great deal of resistance in many services with regards to the movement to EBP, and I wonder how much of that has to do with being in a service which is traditionally isolated. Staff who work in services such as residential and off-site satellite offices frequently have little opportunity to discuss treatment modalities and directives with people other than the insular group they are a part of, and this is an unfortunate aspect of some services. It would be interesting to determine if

other isolated services felt similarly. I now find humour at the irony of those types of discussions, as well as the timing. It feels that I have come full-circle. I, myself, have stopped wanting to live in the past, although it has taken me a long time to get to this point.

One of the questions I asked previously was whether the lack of a Master's degree negates the 20-some years which I have spent in children's mental health. I do not believe it does. I am excited when I can help younger clinicians, graduate degree or not, navigate some of the unwritten rules which exist. There are no instruction booklets that provide new employees with answers to questions that only experience can provide. I have needed to transfer clients to younger staff and I feel for both the family and the younger employee – I have felt the silent cringe on both of their behalf; family members who are worried about whether or not the staff member will be able to help them given their age and level of experience, and the clinicians who fear that the family will not accept them for the same reasons. We all need to start somewhere and we all have started somewhere. I also do not believe having a Master's makes me any better at being more effective in implementing EBPs however conducting research on EBPs certainly has. This is something I would not have done had I not pursued a graduate degree.

I do not necessarily like manualized interventions, however based on my survey, some staff members swear by them and some have indicated that they always use them ("I always use manualized interventions"). While there is no significant correlation between the years of experience that one has and any of the questions I asked, it was clear that feeling equipped to deliver EBPs was more important than any other factor. This is interesting to me as I had assumed that those who had attained their graduate degree in the past ten years or so would have been subject to more education around EBP however this was not necessarily the case. It seemed

that it might depend on the service which one is in and the subsequent training those professionals have had outside of formal academia.

It is interesting how resistance is built into this tension among education, experience, and respect. Based on my survey and my own personal communications (Anonymous, 2011; 2012), both myself and many of my colleagues have been resistant to pursue further education, and resistant to implementing EBPs as they are dictated. Resistance is a theme which emerged as being interwoven throughout the other themes and as such will be discussed throughout the analysis of the data.

Whether or not Foucault had it right, there is a good deal of discussion in the literature about the movement of social work from an art to a science. Foucault's theory of governmentality supports this notion, as the disciplining of oneself depends on expertise (Foucault, 1984). The movement to EBP has resulted in practitioners undertaking a great deal more reading, research, and measuring of outcomes. This movement has resulted in a reshaping of the practitioner's professional identity, a new form of governance over oneself. While the consequence has become a greater acceptance of social work as being more scientifically-based, there is a drawback to this occurring as well. More time is needed to conduct research, and this takes away from the actual treatment of the child and the family. When I worked on the pilot project for anger management, and data collection was the highest priority, I did not feel that I was doing the work that I wanted to do, that I needed to do; the work that motivated me to get into this field in the first place. Parents and teachers were very resistant when, every three months, I asked them to complete the same assessment to determine where their children were at in terms of behaviour. Getting these forms back was even more of a challenge, and if I did not collect them, I was criticized by my manager and those who were in charge of the program. Very

rarely was the focus on the actual improvement of the child at school, home or in the community. If there was no data to support it, the work I did with the child was deemed meaningless.

The implementation of EBP

It has become apparent through my study that there exists a tension between the top-down implementation of EBPs versus bottom-up implementation of EBPs, with some resistance being inevitable. The implementation of EBPs from a funding perspective allows the government more control over the public purse while continuing to provide funding for essential services. While this is a “top-down” approach to EBPs, there is also the perspective of the “bottom-up” implementation of EBP.

Driven from the “bottom,” practitioners who work in children’s mental health are now being drawn upon to do their own research; practitioners are required to provide pre- and post-treatment measures, collect data, and do something with that data to demonstrate that what they are doing is effective. Professionals are somewhat resistant to this, as evidenced in my autoethnography, the literature, and the experiences of my peers. While we, as service providers, are looking for ways of demonstrating proof that what we are doing is helpful, this takes away a good deal of time from actually providing the service which we are there to provide.

One of the key tensions is the definition of evidence, and what constitutes evidence, particularly from a bottom-up perspective. Looking back at my survey, one respondent suggested that there be a governing body who regulates and certifies EBPs. Another challenged who is in charge of making the decision on what is credible or not. While participants were not asked directly about their belief of how evidence should be defined, there seems to be some underlying negativity surrounding this question. Some of my peers in the manualized pilot project I worked in shared the same experiences that I did – that if they did not collect data and the data did not

show an improvement in the child's behaviour, they were deemed as not doing their job appropriately (Anonymous, 2012). Data collection or the search for "evidence" took priority over treatment in that situation, as this was really what the staff were being "paid" to do. Hoagwood et al. (2001) stated that there needs to be some research conducted on the fit between EBP and service delivery prior to large scale distribution of EBPs in children's mental health services. While this statement was made over ten years ago, it still holds true. Both practitioners and the funders need to decide as a team on a definition of "evidence" is as despite this question being bandied about for years, there is yet to be an agreement on by both sides.

Drawing on the work of Deleuze and Guattari (1972), Holmes et al. (2006) attempted to demonstrate that the movement towards EBP is "outrageously exclusionary and dangerously normative with regards to scientific knowledge" (p. 180). Holmes et al. (2006) studied the Cochrane Collaboration (Cochrane, 1972) and the extremely limited concept that this governing body has with regards to research. They determined that a great number of research projects do not live up to the high standard which Cochrane permits as being evidentiary investigations. If one were to look at anything other than a Cochrane approved study as a failure in good research, many of the EBPs which are established as "best practice" would not qualify as such in the eyes of the Cochrane Collaboration. This again speaks to the question who defines "evidence" and what the criteria are that support that definition.

The postmodern movement (Cheedy & Chaboyer, 2002; Winch et al., 2002; Holmes et al., 2006; Porter & O'Halloran, 2009) argued that EBPs are not as effective as they could be. The reason for this is because EBPs exclude all other forms of evidence which are needed to understand how complex treatment is, minimize other essential aspects of clinical practice, and fail to take the individual into account. Respondents to my survey agreed with this. One

participant argued that there needs to be a more holistic approach to treatment and that the client's needs have to be taken into account. Others thought that people from different populations require greater flexibility when they are being provided treatment. The theme of flexibility continued throughout, as stated by one respondent, "I think there needs to be flexibility; to think one has to stick only to EBP may not benefit the client." Postmodernists thus find EBP necessary but not sufficient to be able to provide effective care (Winch et al., 2002; Griffiths, 2005; Scheyett, 2006; Porter & O'Halloran, 2009). Survey participants agreed, stating "research is not as good at determining a one size fits all approach to children but I feel that they will eventually tease these intricacies out with further studies that extend beyond the lab." Another participant also spoke to this and noted, "My work is time limited and I must respond in the moment to the client's immediate need. People are dynamic and may activate many systems and behaviour patterns at once and on a continuous basis."

I cannot overemphasize the length of time it takes to conduct research while attempting to provide treatment. A large part of conducting research is the collection of evidence. More and more, practitioners are expected to identify and use research which is scientifically strong, appraise its application to a specific client situation, and evaluate the client's progress to determine if that intervention was successful (Ferguson, 2003). This is not happening just at a Master's level, in which students undergo a significant amount of training in how to conduct proper research. This is also occurring on the college and undergraduate level as well, where education is less focussed on research. There are gaps in knowledge because of lack of training. Practitioners are expected to perform research despite not having the proper tools and awareness to do so. This creates a great deal of stress for many practitioners in those roles, and this stress is not necessarily validated nor accounted for by management (Anonymous, 2012). Mor Barak et

al. (2001) stated that the limited knowledge of relevant EBPs amongst social workers is so rarely addressed that social workers themselves are expected to address these gaps. Lunt et al. (2009) agreed that finding time for research by practitioners is very difficult to do, as practical work demands their full attention. There is little mention about how caseloads and time constraints factor into this expectation. Taking all of these factors into consideration, it is no wonder there continues to be resistance to this movement.

When I first decided to pursue this research, I was unsure of my knowledge of EBPs and wanted to explore the experiences of other professionals. It is now clear to me that I am not alone in my concerns about the shift to EBPs and the role that funders play in the decisions to shift to EBPs. Based on my survey, there seems to be some anger towards the funders and the government, for the implementation of and direction to provide EBPs alone.

Unfortunately the ministry people making decisions have little to no clinical background - when they see that a problem can be cured in 8-12 or whatever sessions as promised by most EBPs, what they see is that we can see more people and "cure" more problems in less time and thus for less money - they then make asinine recommendations or ideas for spending budgets that have nothing to do with client centred approaches that they also preach.

While some participants agreed with the shift to EBPs, many indicated that the people who make the decisions regarding such changes do not understand front line work. I have a sense of pride in that I work in the children's mental health field with many other professionals who, despite the limitations which are implemented from a higher level, maintain the needs of the children and families as their highest priority.

I believe that there is a danger to using a "one size fits all" approach to working with clients. I can appreciate the importance of using treatments which have been proven to be effective, particularly with the shift towards shorter term treatments, as agencies try to meet the needs of more people, with fewer staff and resources. EBT's provide a useful structure; however flexibility is also needed if treatment is to be client-focused.

Frequently, when a child moves through different services such as residential treatment, day treatment, outreach (a worker goes into the home to provide hands-on treatment), the therapist changes based on the service the child is in. Throughout their treatment, a child and his/her family could therefore have four or five different therapists. This means the family have to establish relationships with someone new, telling their story over and over again, and attempting to get used to different personal styles. Given that “a practitioner’s skills and style are critical to the success of any intervention” (Waddell, Godderis, Wond, Garland, 2005, p.7), including the ability to establish therapeutic relationships with the client, this makes continuity of treatment very difficult. I have to admit, over the course of my work, I have broken this rule on occasion, and continued to work with a family even after they have left the service that I am assigned to. While this has caused some professional/personal issues for me, I have done this because I have been very concerned that the child and/or family cannot manage yet another change, and that progress would be lost as a result. Unfortunately, professionals seem to get caught in these types of situations in which they need to make a choice between addressing what is in the best interest of the client or satisfying the funders or management team.

A young man was transferred to me who was so angry that he would enter into an explosive rage every time he saw me. He had anger management issues, and I was a trigger because he did not want to have to deal with yet another therapist. I do not agree that having to transfer therapists is fair to anyone, practitioner included. As professionals, we continue to reinforce the necessity of continuity and predictability with our clients – to schools, parents, and anyone else with whom they may be involved, yet this does not seem to pertain to us. If parents or children protest and want to maintain the same therapist, they are seen as being resistant and attempting to manipulate and ‘pick and choose’ whom they wish to work with. The need for the

therapist change is because of funding in that different services are funded in different ways and if the therapist attached is part of residential services and the child moves to outreach, the people working with that child need to change as well.

This example fits into the Foucauldian concept of the silenced voice, moral fault, and the relationship between power and knowledge (Foucault, 1991, Scheyett, 2006). Despite the needs of the client, the governing body uses its power to limit input into treatment for economic and political motives rather than individual and mental health reasons (Scheyett, 2006). Foucault (1991) emphasized that the voices of those who were considered ‘mad’ were silenced, and not given any voice by those who were perceived to be in a powerful role, including when wanting to remain with a therapist. Clients are perceived as demonstrating moral fault (Scheyett, 2006) indicating that there is something inherently wrong with them and therefore, requiring assistance from a more powerful individual to help them become right again. Individuals who were deemed to be ‘mad’ are placed under the surveillance or ‘gaze’ (Gilbert & Powell, 2009) of those who had more knowledge and are in power, to ensure that they manage to shed their differences and become like the rest of society. Changing therapists allows for more than one professional on the front line to be able to monitor clients from different perspectives and areas of judgement.

The ‘gaze’ also occurs in the role of the therapist, with relation to management and government as well. In many ways, the voice of the practitioner is silenced and they are ‘watched’ to ensure that they are following what has been dictated and to ensure that what is being funded is actually being conducted. Even if the therapist attached to the client in one service does not agree with the transfer to another, the decision is made at a management level. This decision is generally absent of emotion, and based more on financial concern and the way the services are funded. Ensuring that regulations are being followed is not always a negative,

and is the way of society as a whole. It involves the same issue as the implementation of EBPs in that the voice of the client is not always being heard, and there is little room for emotion.

Foucault's notion of governmentality underscores the reality of this and of what exists today and has existed previously. It is hopeful that this will change in the future, with resistance from those who experience it on a front-line level – both clients and professionals. It is resistance to this governmentality which results in change in the long term and contributes to the ever-evolving shift in practice, on all levels.

The implementation of EBPs has resulted in a limit in that the number of sessions which are allotted to a particular child or family based on the diagnosis of that child. Participants in the survey indicated that this causes them concern and stress in their delivery of service.

I feel some symptoms can be treated using EBPs, holding steadfast to EBPs as the only method to use will disengage some clients and also promote the idea that our client's problems can be solved or "cured" in 8-10 sessions - not true at all and misleading for the clients.

I have recently had similar experiences in terms of time limitations. In my new role, I have found that I have needed to explain to families (after they have waited for months for service), that they have qualified for one to two sessions, based on the scores from an interview they have completed. Some people are quite fine with this, believing that a check-in with a professional is really all that is needed to make sure they are on the right track. Others are not so pleased with this, and become angry that all they are able to receive is what I present to them. If parents are fortunate enough, they are able to make use of their Employee Assistance Program (EAP) in order to access private counselling for their child, or they decide to pay out-of-pocket for the expense of personal therapy, instead of waiting the length of time it takes for their name to be taken off of the wait list for "free" services.

Waitlists have resulted in a two-tiered system in children's mental health, whereby those who can afford it are able to access services in what may be a life or death situation, depending on the severity of the symptomology and diagnosis. In what is generally the norm, children do not have a diagnosis before they come to an agency and many try with great difficulty to access a child psychiatrist. Finding such a specialist is a very difficult task, the reasons for such difficulties being outside the scope of this research.

My recent experiences though, have indicated that should parents question the number of sessions and believe their child needs more, they may indeed receive that. This is based on the level of motivation which the child and family exhibit, as well as the stage of change they are in at the time. If what I am providing is working, and we can demonstrate that, or provide "evidence" to this, I have some flexibility to provide further service. I have found this to be a real positive which has resulted from the shift to EBP in that this provides me with the opportunity to discharge clients who are paying lip-service to wanting treatment, or who are not yet ready for change. This has been a helpful experience for me in that it has allowed me to deal with demanding parents without the need to look at the power-relationship, and me needing to say no when the family is not ready to accept that.

Many of my peers discussed level of motivation and stage of change as well, in their survey responses. It is very clear that when discussing the number of sessions, the child's stage of change needs to be considered. If the child or family is not ready to shift, adding extra sessions to an EBP is not going to make a difference. Some colleagues agree and one suggested that there are some clients "with whom EBP does not work the greatest based on what level of support they are looking for and where they are in the stages of change." Another respondent wanted to ensure that levels of motivation and stage of change were taken into account in the

assessment phase, adding “you can have a great program that has shown to be effective but if the client is not engaged it will not be helpful.” The stage of change also needs to be accounted for in terms of length of treatment which is allotted. One respondent argued this to be a cost-saver for agencies, stating “agencies unfortunately use EBTs as excuses to limit sessions with clients - if the EBT research has proven effective within a certain number of sessions for example, agencies want this to be applied to the entire population we serve...not possible.”

Being able to determine the motivation level of the client is paramount in determining what approach a professional will take to provide treatment. Sometimes, just letting the family know that they are not ready will provide a catalyst to make them ready for change, and other times, it allows them to lower their expectation level. This is a positive of the movement to EBP as it prevents the misuse of time and allows the focus to be on those individuals and families who are ready for change.

To return to the discussion regarding the clients who are transferred to a new therapist, often this can happen in the middle of some terrific progress. A family might have established some success with residential treatment and is moving on to a less intrusive service, such as outreach; however, the relationship with the therapist becomes disrupted because it needs to change, and there is usually little room for flexibility. It is my belief and the belief of my colleagues that there needs to be room for this kind of flexibility, and that this is where there needs to be greater respect for the experience and professional judgement of the therapist, as well as the requests of the client. “My main concern is when session numbers are limited and therapists are told you should be able to achieve success with, for example, ten sessions, but no account of rapport, trust, motivation and engagement is factored into that equation” responded one participant. In my new role, I have been told that I have this flexibility, so long as I

document it and confirm it with my supervisor. Again, this is due to the need to justify to the government that we are doing what we say we are going to do. The ability to govern oneself or someone else depends on expertise (Winch, Creedy, & Chaboyer, 2002) and consequently, those who are considered ‘experts’ end up shaping what needs to be governed and then provide assessment, judgement, and evaluation of the professionals who provide EBP to clients.

In looking at the implementation of EBPs from a “top-down perspective” I have considered the concepts of governmentality and power (Foucault, 1991). In looking at its inception, Foucault (1970) believed the development of social work was a result of the marriage of the legal system and the psychiatric system, whereby those who did not fit in and were viewed as troublesome were separated from the whole and institutionalized. Social workers have therefore taken on the ability to police others and subject them to surveillance and correction, based on the manner in which they behave. It would appear that the development of resistance towards EBP has occurred very quickly in reaction to its implementation because in part due to the definition of evidence as well as the definition of EBP have not been consistent. Governmentality, power, and resistance become the focus of the delivery of service and then it becomes very unfortunate that there needs to be such policing and that the best interest of the client is not what is front and center.

It is clear that EBP allows for a more closely monitored system in children’s mental health, in that practitioners need to demonstrate that they are using established interventions, and that they are measuring outcomes. Foucault described a “panopticon” (Garrett, 2005) principle that he likens to a high-surveillance prison with cell blocks which are situated around a central area, which allows for monitoring of the prisoners at all times, without the prisoners being aware that they are being watched. This concept also exists in children’s mental health; this panopticon

allows the close supervision of professionals and ensures that the ‘gaze’ continues to be on the child with the mental health diagnosis, regardless of whether or not they are aware this is occurring.

In looking at the evidence-based movement in medicine, based on Foucault’s (1978) writing, it can be extrapolated that he would have argued that the shift to implementing EBP in social work could be viewed as remarkable. It would be something that he would expect would backfire, and that such an obscure political movement can actually work backwards to “incite, reinforce, control, monitor, optimize and organize the forces under it” (p. 136). This concern was regarding the possible rebellion which may occur as a result of imposing a shift to a phenomenon that people are not yet ready to undertake. Perhaps we are starting to see the beginning of a quiet revolt such as what he was referring to, as the dissemination of EBP has not occurred quite as smoothly as expected. Resistance continues to be strong on many levels, just as Foucault (1976) has stated that resistance is not just a single reaction to a course of power, however as a result of multiple reactions to that power over the course of time (p. 95). In regards to Armstrong’s (2008) interpretation of Foucault, resistance is produced by the very power which it is resisting against, and there are many forces making up the resistance movement in EBP.

As professionals in children’s mental health, we are quick to seek out diagnoses, as having a diagnosis from the DSM-IV (2000) allows us to choose an intervention which is evidence-based. This provides us with an intervention, as well as throwing the client into the spotlight of having a label, which puts them into the ‘gaze’ of others. Frequently, this allows service providers to hide behind the privilege and the power of the intervention and the EBP administered (Keenan, 2001). As a result, a diagnosis tends to strip some of the personal characteristics which both the client and the professional bring to the relationship. It then takes

on the persona of the professional being the one in the know, and the voice of the client is therefore silenced.

Heaton (1999) argued that the movement of the implementation of EBPs in professions that provide care to others has increased the status of those service providers at a government level, increasing the level of surveillance. This viewpoint appeared to be a take on Foucault's (1977) perspective that professionals are watched firstly by the clients and then by the continuous review of client needs, and that management continues this 'gaze' in terms of supervision of the professional. The 'gaze' will continue to be so much wider-spread than this as it extends to government levels. That is to say, the movement towards EBP is not going away and, like anything new, it tends to become overbearing and over thought until the funders are confident that we are doing it properly, then it takes on a more relaxed approach. Much the same as the earlier example of baking a cake for the first time – follow the recipe with strict adherence until you understand it completely, and only then can you make substitutions. Gilbert and Powell (2009) discussed what Foucault called “the microphysics of power” in which opportunities for resistance come from the bottom up. Surveillance can, on the one hand restrict practice however, on the other hand, the complexity of it opens up room for resistance and for dialogue, which can create new formulations of power relations.

Foucault would label this as the dance which occurs between those individuals who have power and those who are watched or surveilled because of this power (Gilbert & Powell, 2009). Resistance results in pushing back at the state, whether that be by overt means, such as striking, advocating or outward refusal, or by more covert means, such as saying one is implementing EBPs however doing something entirely different or just not using EBPs at all. This demonstrates the impact of power and resistance and how clearer definition of EBP needs to be

made at the government level. Biggs and Powell (2001) however, cautioned against this dance, stating that this can lead to a trickledown effect. This is an effect which may result in a similar resistance between professional and client, and a subsequent stagnation in the delivery and acceptance of service, should they not both be more accepting of the direction in which EBPs are headed. It would appear that front-line practitioners are caught in the middle to a degree, as they need to heed what they are being directed to do, as well as be able to be confident that what they are being asked to do is considered best practice, in their own viewpoint as a professional. There are few things worse than being told to do something with a client when you are not totally in agreement with this direction. Clients are very intuitive and can tell when you do not believe what you are doing yourself, and it will end up being counterproductive. If the therapist is not comfortable with what s/he is doing, it is very difficult to get the client to the point of being comfortable as well.

From my own perspective, as stated before, I have struggled with and resisted the movement to EBP, contending that it has been too restrictive. My colleagues did not always agree with me in that many expressed that EBP was helpful. One respondent indicated that it was “useful when speaking with parents about the methods you are using with your clients as you can provide them with research,” which for me, was a different perception on the value of EBPs. Another stated that it “provides a solid framework for treatment of mental health issues and can be easily adapted for the particular needs of a client.” Feeling equipped to use EBPs in their work with clients was the strongest indicator of confidence level in implementing EBPs and not worrying about feeling embarrassed by lack of knowledge. Conversely, not feeling equipped led to higher anxiety around using EBPs.

Scores on the question about worrying about being ‘caught’ not using EBPs were also interesting. Those participants, who indicated that they did worry, felt more nervous about asking for more information because they felt that they should know more, and admitted to writing EBPs into their treatment plans without the intention of using them because they felt that they should include them. Those same individuals felt that EBPs do not contribute to the effectiveness of their work with clients. There was also a converse relationship in that those respondents who were not worried about being caught did not feel nervous to ask for more information, and did not write EBPs into their treatment plans without the intention of using them. These practitioners also believed that EBPs contributed to the effectiveness of their work with clients. This speaks more to the need for more training to help ensure that clinicians feel more equipped to use EBPs in their practice and at the same time, speaks of how those practitioners who do use EBPs and are comfortable with them, believe that they are helpful and add to the effectiveness of treatment.

Value of Relationships

I am firm in my belief that relationship needs to be the key in any type of therapeutic alliance. In their exploration of truth, power, and fascism in health care, Holmes et al. (2006) supported this statement. The authors argued that an evidence-based world view is oversimplified in that it fails to take into account personal and interpersonal connotations of a world which is fundamentally based on relationships. One participant in the survey responded that they were aware that research shows that the most powerful indicator of change is the therapeutic relationship, which accounts for 50-60% of the change which occurs in any kind of therapy.

Scheyett (2006) believed that EBPs are based on a hierarchy which does not acknowledge the substance of client first-person accounts in which the clients are not heard and

do not count as “evidence” (p. 75). This is supportive of Foucault’s (1991) notion of the “silenced voice” in that EBPs seem to have little room for the exploration of what the client himself is experiencing. It also supports Foucault’s (1991) theory that power and knowledge are interwoven and how very little power the client has in the client-practitioner relationship. This is evident even more so when you look at EBP.

Larner (2004) did not agree that EBP could fit into family therapy as the nature of the treatment itself was based on the relationships of those within the family. Hall (2008) suggested that putting clients into categories provides a barrier between the client and practitioner. There seems to be resentment and thus a resistance of the movement towards EBP, in that it takes away from the relationship building aspect which is viewed as so important when moving into a helping relationship (Beddoe, 2010).

While research may be able to determine what works best for some clients, it also limits what is measured, and often there are areas of improvement which cannot be measured by a pen-and-paper assessment (Gibbs & Gambrill, 2002). There has been the suggestion that there needs to be a more suitable tool for measuring therapeutic approaches which do not fit so neatly into the medical model (see Webb, 2001; Gray & MacDonald, 2006; Blom, 2009; Van de Luigaarden, 2009). One of the survey participants is also hopeful that this will occur. “Research is not as good at determining a one size fits all approach to children but I feel that they will eventually tease these intricacies out with further studies that extend beyond the lab.”

Timing continues to be a theme within all themes. The fact that there is a waitlist puts up an immediate barrier to the client-therapist relationship, as frustration grows by needing to wait for service, and behaviours could deteriorate during that time. Practitioners always need to work extra hard to establish that relationship as there has already been some souring of the experience

which manifests as a result of needing to wait. Further work needs to happen when that initial phone call is made, and the clinician notifies the family what kind of service they have qualified for. This is conducted immediately so that the client knows what to expect right from the start. This has been another component of EBP that can be viewed as either being a help, or a detriment. I have had parents tell me that being aware that they have only a couple of sessions has resulted in them “getting right into the heart of the matter,” without wasting time with trivial conversation (Anonymous, 2012). I have also found this has made some families more resistant to telling their story and wanting to make that connection, as it could be viewed as a lot of work for little payoff.

Another aspect of timing is the number of sessions which are allotted for a client’s diagnosis and for the EBP to be implemented with them, based on that diagnosis. Quite often, I receive a summary of a child’s behaviour with an attached diagnosis such as anxiety, for which CBT (Cognitive Behavioural Therapy; Beck, Rush, Shaw, & Emery, 1979) is recommended as the treatment to be implemented. I know immediately that when I see that, I am expected to have eight to ten sessions of manualized intervention. This does not account for the development of the relationship, the wait that the family has experienced, and what has transpired since the original behavioural summary was written. In my autobiography, I spoke of several manualized interventions and discussed how the relationship is accounted for. My colleagues agreed.

My biggest concern is when session numbers are limited and therapist are told you should be able to achieve success with for example ten sessions but no account on rapport, trust, motivation and engagement is factored into that equation.

More research needs to be conducted on the role of relationship-building within EBPs and there needs to be more dialogue about the balance of these rapport and treatment interventions. This also needs to occur simultaneously with training opportunities.

Need for Training

I am of the belief that counsellors and therapists enter into this line of work because they want to help others, certainly not for the financial pay-off. Training is very difficult to obtain as it is expensive. The people who make decisions to fund agencies who utilize EBPs quite often sell those agencies short in that they expect that EBPs are being implemented; however, they do not provide adequate funding to ensure that the skills are at their highest level for this type of service delivery. Pre- and post-treatment outcomes are measured, and I believe all front-line staff should be proud of how much improvement their clients are demonstrating as a result, with limited training in new EBPs.

I also believe that some of my colleagues sell themselves quite short, in thinking that what they provide is not evidence-based when in fact, it is. The manualization of some interventions seems to skew the viewpoint of some people and cause them to doubt that they, as professionals are indeed being effective, as well as providing EBP, when in fact, they are doing both. Because some people do not use manualized interventions, which are actually an EBT, they are not aware that they could still be using EBP. Because of the lack of understanding in this area, some of my colleagues refused to participate in the survey as they were concerned that as professionals, they would be discovered as not using EBPs. While there is no way of knowing what the reason was for some people not participating, this was the viewpoint I received in feedback from some of my colleagues, despite the fact that this was unsolicited. This outward refusal to participate made a profound statement as there was the perceived risk of being exposed for not using EBPs and this can be attributed to the lack of training as to what exactly EBP is.

Many survey participants agreed that they need more training – not only in EBPs but in other modes of treatment intervention as well. This is because professionals need and want to

feel confident that what they are providing is what they are being asked to provide. By virtue of some participants not being confident in their understanding of the differences between EBP, EBT, and EIP, it is clear that there is some nebulous understanding of the treatment modalities which they are actually using. While the transformation to using EBPs has been expected, there are still pockets of practitioners who have not had sufficient training to help ensure they are being incorporated. This remained true with regards to formal education as well. Some participants found that EBPs were highlighted as part of their degree; other programs did not address EBPs.

In the survey, a number of respondents stated that they need to understand how EBPs can be modified to best accommodate clients with exceptional needs. Modification is not easy to do with manualized interventions which have fidelity checks to ensure that EBPs are being implemented properly. One respondent suggested that “EBP – especially strict manualized programs – have been validated on a very specific group of children...and that some EBPs are too rigid to meet the treatment needs of certain clients (i.e. dual diagnosis) and so stringent application of the EBP would eliminate them from this treatment modality.” If a client does not meet the criteria of the treatment, that child may miss out on treatment all together. Another respondent made an interesting point about academic ability, and that “many EBP are created for literate people...I have modified many programs to meet the needs of my elementary aged clients.” This speaks to another concept which has rarely been discussed in the literature.

While many of these assertions reflect the practitioner being flexible within the administration of EBPs with their clients, these statements also speak to the level of training which must be given before EBPs can be varied. In my autobiography, I spoke of the comparison of adapting EBPs to individual characteristics being akin to baking a cake. While you may need

to have a full comprehension of the recipe, if you are making it for someone who is gluten- or lactose-intolerant, it needs to be modified immediately, not after feeding it to them several times and wondering why they are getting ill.

When asked in my survey about the kinds of training that practitioners would like, many responded with training in adapting EBPs for specific client groups. “Training in adaptation EBP models for (children and adult-parents) with learning disabilities, FASD, Autism, ABI, complex attachment based trauma and RAD,” was requested by one participant. Another stated that “new, primary-based practices would be helpful, with limited reading and written expectations.”

The movement towards EIP and away from EBP was also supported by participants who completed the survey, suggesting that “... a shift away from the rigid EBP and EBT and would like to see things move in the direction of more evidence informed work, allowing for more flexibility, meeting client needs, respecting skills, and the square peg round hole phenom.” One respondent indicated “in my opinion, (EIP) is a better practice, takes a more holistic approach, allows practitioners to use logical parts of proven research and techniques that may apply to or meet a client's needs, and blend it with other tools.”

It is interesting to hear the voices of those who work in direct service delivery and who need to demonstrate that they are implementing and utilizing EBPs every day, with every client. Clearly there is a need for more training, and this needs to be considered when funding is being decided. The need for training is, unfortunately, evident in the level of concern that participants had that they would be discovered or “caught” not using EBPs. This was additionally apparent in that some people did not feel confident discussing EBP with their manager or their peers.

The notion of the need for training and the lack of funding for it also speaks to Foucault's (1991) concept of governmentality and the movement to develop further control over various

institutions including social services. By changing the way that children's mental health is funded to being much more stringent in funding only EBPs (Barwick, Boydell, Stasiulis, Ferguson, Blase, and Fixsen, 2005) there is further rigidity in the way in which money is spent. The control over funding has resulted in four different conditions occurring: no training; minimal training; very inflexible training on a specific EBP; or paying for training out of one's own pocket. I am aware of several of my colleagues who have done the latter (Anonymous, 2012). If a practitioner wants to improve their practice and there is no money available for this to happen out of the public purse, they might end up doing this on their own. This is similar to my return to university in that if I want the position that I want, I need to pay for my own education or do without. There has also been some further self-initiated movement as well for professionals to attain low-cost or no-cost training and that is through the use of webinars or on-line seminars. While these training modalities may or may not be evidence-based, they are providing somewhat of a need fulfillment for those wanting more. By virtue of limiting funding for training, it is apparent that funders hope that more and more staff members will take on the financial payment of training. If EBPs are insisted upon and necessary, and there is no funding provided for training, practitioners will need to learn on their own, and thus pay on their own.

The Elephants in the Room

Throughout my research it became apparent that there are elements of EBP of which we shall not speak. These are what I refer to as the 'elephants in the room.' This occurs on at least two levels: that specific to practice, and that specific to the discussion of EBP. The first item that has been ignored is the tendency to address behaviour without addressing the root cause or the reason behind the behaviour. The second one is being the movement to EBP and how it has been

imposed however it seems to be a quiet expectation, one that is rarely spoken of out loud, for many different reasons.

In thinking about the first item, I look back at my autobiography. I had discussed an example of a clinical situation which was clearly an example of this type. I shared a loosely-based anecdote of two boys who were in a horrific car accident, and how they never spoke of the fact that one of the boys actions resulted in severe bodily harm and death. The accident and its aftermath was the kept quiet in that everyone was aware of it but no one wanted to address what had occurred. The school was concerned about the child fighting with his peers. Relatives were concerned about the boy fighting with his brother. No one had ever addressed the root of this boy's anger, nor his guilt or confusion or any other emotion which he may or may not have been experiencing. Everyone wanted the boy to learn to manage his anger. He was given an EBP for anger management but with very few results. When he was calm, he knew exactly what he should have done, how he should have acted, and was able to cite verbatim what the manual stated. He still became angry, yet I was not paid to address the trauma. I did not have enough sessions to address the trauma and should I have used my professional instincts and explored this further I likely would have been reprimanded. I needed to stick to the plan. It is difficult to back this up with research in the literature, as it continues to be something which is unaddressed. Should an EBP be developed for a specific behaviour, it will address that behaviour only; however should an EBP be developed for trauma, it will address the trauma, but not the behaviours which can cause such difficulty for children. Again, we are looking at co-morbidity.

In looking at co-morbid mental health issues in children in the survey, many of the participants expressed concern that utilizing EBPs can actually inhibit treatment. There was an acknowledgement that a "one size fits all approach" does not always work with a child with one

diagnosis, let alone a child who has more than one. The premise that continued to be prevalent was that of adaptation and flexibility to meet the client's needs. "I feel some symptoms can be treated using EBPs, holding steadfast to EBPs as the only method to use will disengage some clients and also promote the idea that our clients problems can be solved or "cured" in 8-10 sessions - not true at all and misleading for the clients."

Co-morbidity is often regarded as two or more separate disorders occurring concurrently (Hranov, 2007) however trauma does not necessarily fit into such a neat package. Children do not always have the ability to articulate their feelings and thoughts, and thus diagnoses are based to a large degree on presenting behaviours alone, and often the reasons for acting out are left unaddressed. Co-morbidity has traditionally caused concern for RCTs (Hoagwood et al., 2001) in that treatments are generally designed for a single Axis I disorder, and patients are assessed to ensure that the diagnosis which is being treated is free of as many variables as possible. Trauma is a very complex variable. The goal however, is to make certain that a treatment modality is effective for the diagnosis which is targeted. These treatments become manualized and post-measures are conducted to determine if symptom-reduction has been achieved.

Currently, funders for children's mental health require that research proposals are tied to categories defined by the DSM-IV (APA, 2000) in order to be considered for financial support (Westen, Novotny & Thompson-Brenner, 2004). As a result, the application for funding has been narrowed down to a single diagnosis. Westen et al. (2004) consider this to be problematic as a result. Current data suggests that up to half of those individuals who seek treatment for mental health concerns do not "fit" in one category, and often will cross thresholds for another diagnosis. A client who presents as being anxious can be treated with an EBP tool; however, if

gender confusion or previous abuse is the root of that anxiety, it is difficult to determine whether the treatment will be effective if the root is not dealt with.

The second ignored item is at a clinical level as well, but has more to do with the way in which we deliver service. The movement to EBP has been positive in some regards, as evidenced in both the literature and the survey. When the time is taken on a dissemination level to provide proper training and dialogue, it can work very well. When there is an assumption that it is being used, with not enough managerial support or training, there is a tendency to not want to speak of it and shy away from discussion.

The fact that many people did not complete my survey is more than likely due to time constraints or not wanting to complete yet another task as people are busy. What speaks very loudly is the outward refusal of some people to complete it, and the lack of discussion about EBPs with managers and with peers. Some people indicated that they have never discussed EBPs with their manager, nor do they plan on bringing the topic up unless they absolutely have to. It is difficult to understand how this occurs when there is such a push at the ministry level for the dissemination and implementation of EBPs. The cost of training is prohibitive at the best of times and if it cannot be provided, there is an unspoken assumption that practitioners will find the means for this on their own. An elephant in the room, indeed.

Based on the results of my survey, I also found that there are other people who do not necessarily believe that manualized interventions are the crux of their work either. Again, something that is not discussed outwardly very often. It was evident however, that many use EBPs and agree that they contribute to the effectiveness of their work. “EBP allows clinicians confidence in one’s therapeutic work and allows for specific interventions and strategies that may be individualized in treatment.” Another participant answered “If you use EBP you increase

the likelihood that the treatment will work and it provides guidance into how you can be most helpful to your clients.” Some professionals operate in programs which are purely evidence-based, such as Incredible Years (Webster-Stratton, 2001) or SNAP (Koeogl et al., 2008) while others do not have manualized interventions which are strictly adhered to.

In addition to the political issues that are not being examined on a front line level, there is the concept of burn-out amongst professionals who are in those programs that are manualized and offer a certain number of sessions. While the names, faces, and situations of the children who have different diagnoses change and there are vast differences amongst them, the prescribed treatment is not supposed to change to any great deal. While such interventions become easier over time as they are implemented over and over, the repetitive nature can cause one to tire of the delivery and execution of these practices. This can lead to more frequent job turn-over and less experienced people entering into the field, which can result in agencies that continue to be in a developing mode as opposed to being able to maintain those professionals who are rich in experience. The loss of seasoned veterans also demonstrates the loss of training and in return, drives up the overhead cost of education from within.

Chapter 7: Conclusion

I have been ambivalent and sometimes quite negative about the implementation of EBP in children's mental health and this has served as a catalyst in my motivation to conduct the research for this thesis. I wanted to determine if my fellow practitioners had the same or similar hesitations. In the last decade or so, there has been a shift to EBPs guiding the treatment process and movement away from the 'tea and chat' kinds of supervision in which interventions were discussed based on the experiences of the therapist, manager, and those of others. This drive has taken on a much more scientific approach and has resulted in interventions which include both pre- and post-intervention measures to determine that the chosen treatment is targeting the problematic behaviour. EBP has been deemed as being much more cost-effective. Concurrently, this shift has happened alongside the movement in social services towards a tighter emphasis on formal education, with job classifications being far more rigid with regards to educational criteria. I have been significantly impacted by this, both professionally and personally.

There are several conclusions which can be derived from this research. The previous chapter discussed themes which have become evident throughout this study. From these, some clear messages have emerged. The analysis of the themes indicates that front line staff have been wanting to communicate with different management levels and with funders, and what they are attempting to relay really needs attention. It is clear throughout my autobiography and with the feedback from the surveys that professionals believe that funders are not aware of some of the difficulties in the implementation of EBPs when it comes to practical application. Clear messages are indicated in the themes which have emerged throughout. The themes included the following: the tension among education, experience, and respect; the tension between the top-down implementation of EBPs versus bottom-up implementation; the importance of therapeutic

relationships; the need for training and the tendency to avoid discussions of important issues that need public airing. There are also some important positive conclusions which can be made with the movement to EBPs, which I had not considered in the past. My viewpoint has changed considerably and while I am not entirely convinced that a pure shift to EBP is the way to go, I think my understanding of EBP is different and therefore the rationale for using it has changed for me.

In terms of funding, there is a general agreement that in this society, we all need to be held accountable in spending from the public purse, and children's mental health is no exception. The implementation of EBP has allowed the funders to have more control over how money is being distributed and how it is being utilized (Barwick et al., 2005). On the whole, however, it is argued that this is putting limitations on treatment provision (Webb, 2001; Gray & McDonald, 2006; Van De Luigaarden, 2009). By and large the EBPs which are being funded target only one set of issues such as anxiety, anger, or depression (Westen et al., 2004), that a client may be experiencing. Children in particular, do not always fit into a categorically defined group, not to mention those who struggle with more than one diagnosis (Hoagwood et al., 2001). Furthermore, there is the knowledge that research supporting EBPs is conducted in a lab-type setting, and to move a research-based intervention into a real-life situation is not always practical or effective. While frequently RCTs are used as the gold standard of research, there is very little room for control in a clinical situation (Melnik & Fineout-Overhold, 2005), and while pen-and-paper assessments to measure outcomes may or may not indicate improvement, the very real question is what constitutes evidence in these circumstances, and who defines what evidence is.

The most glaring concern expressed in the survey, my autobiography, and the literature, is the role of the relationship in the client-therapist dyad. EBPs do not appear to account for the

time it takes to establish rapport, and in most manualized interventions, there are an assigned number of sessions which are allotted. Due to time constraints and waitlists, one cannot go over and above these sessions as anything lengthier is not funded. This is a real source of anger for professionals that I share. I believe that this anger is warranted. Limiting sessions is inappropriately restrictive, and there is a lack of respect which is perceived and expressed, as this restricts the decision-making ability and professional opinion which the individual brings to the practice of social work.

For this reason alone, there is a great amount of resistance to the idea of and implementation of EBPs in children's mental health (Humphries, 2003; Blom, 2009; Beddoe 2010; Anonymous, 2011; 2012). With the limitations of funding also comes the limitations of proper training that is allotted to those in social work, and thus the dissemination of knowledge becomes a bigger issue. Many practitioners refused to complete the survey, and reports as to the reasoning behind this indicated that they do not know if they are using EBP the way in which they are supposed to be. Some practitioners indicated that it is because they are unsure what exactly they are supposed to be doing. Others do not particularly like what they think they are supposed to be doing, that is using manualized interventions. There is a fear that this will be discovered.

I mentioned one problematic area in my autoethnography, when I discussed how children are being taught anger-management strategies, and the cause of their anger is not being addressed. The targeted behaviour is what is being measured, regardless of the reason the child is behaving that way. The root of what is driving the behaviour needs to be addressed as all too frequently, it is the symptom of an underlying cause. Having control over one's actions is crucial, however to a child, being able to identify what is being experienced internally is

generally not possible without a trusting adult who can help explore this in a caring manner. This needs to be addressed so that professionals do not believe that they are providing a mere band aid solution, and that there is no time to work through this. Ensuring that the underlying problem is identified and dealt with, there is less possibility of re-referral for more help.

There is a similar theme which is happening in my experience of EBPs - that is with regards to the dissemination of EBPs in children's mental health. As I mentioned previously, the implementation of EBP can often take the form of an assumption that because it has been mandated, and the funding is for EBP that front-line staff are using EBP with clients. This assumption is often in place even when there has been little training or discussion around the implementation of EBP. When there is an assumption that EBP is being used, but there has not been enough managerial support or training, there is a tendency for front-line staff to avoid talking about EBP. As was demonstrated in the survey results, front-line staff may not feel comfortable asking for clarification about EBP from management or peers. It appears that while everyone is talking about EBPs and attempting to implement them in practice, there is a clear expectation that EBPs are being used. With lack of training and an underlying fear of reprisal, as well as no clear discussions occurring, EBPs have seemed to become a bit of a mystery which is guarded and avoided.

Many of the participants in the study have asked me about the results of the survey, and they are excited that their voice and the voice of their peers may have an opportunity to be heard. These professionals genuinely enjoy helping children and they want to continue to become more effective at it. Many have expressed hope that this research will be read at the Ministry of Child and Youth Services level. Despite the mixed experiences of the movement towards EBPs, there exists a wide belief that there needs to be flexibility and not just rigid adherence to utilizing only

those interventions which are funded, in a cookie-cutter manner. In order to move forward and be as helpful to clients as possible, there absolutely needs to be room for this kind of flexibility, which takes the client need as well as the practitioner's judgement into account. Open discussions about how EBP can be implemented and the role of flexibility in its implementation are an essential but often absent part of this process.

Prior to conducting this research, my knowledge of EBP was that it was strictly a manualized intervention, such as *The Incredible Years* (Webster-Stratton, 2001), *The Coping Cat* (Albano & Kendall, 2002), or *SNAP* (Koegl et al. 2008). I now know that was I was referring to was EBT. I believe that others share in this confusion, and this is substantiated based on some of the answers in my survey.

Given that there are several different definitions and interpretations of what EBP is or what it seems to be (Sackett, 1997; Drake et al., 2001; Iowa PIC Project, 2003; State of Oregon, 2003; Clegg, 2005; Godderis, 2005; Waddell et al, 2005; Pollio, 2006) there is no wonder that the dissemination of the shift towards implementing it in children's mental health has been problematic. Consistent definitions of EBP have not always been used when implementing them in children's mental health. Sackett's (1997) definition seems to be the most widely accepted within this field, which is "the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients" (p. 3). Often however, when EBPs are spoken of, they are interpreted to be manualized interventions which are found to be effective in treating a given diagnosis. The belief then seems to become that it is manualized interventions which are viewed as what is being discussed and insisted upon, which subsequently overly simplifies the definition of evidence and therefore limits the role of evidence for professionals (Clegg, 2005; Pollio, 2006). As Blom (2009) stated, EBPs then become a tool which ends up

using us, as opposed to the other way around. The need for a consistent definition of EBP needs to be prioritized before it can be implemented successfully to the point in which the front-line staff feel comfortable enough to be able to recognize whether or not they do, in fact, use it.

The next step needs to be a better understanding of what is evidence. If it is solely based on RCTs and quantitative measures, there will never be a clear definition of evidence in this given that there no accommodating for the clinical environment and individual differences, let alone co-morbidity. There can be no fundamental distinction between that which is quantitative when the concept of qualitative evidence is characterized as being labelled ‘intuition’ (Devisch & Murray, 2009). Porter & O’Halloran (2009) concurred, stating that the idea of ‘best evidence’ is hierarchical and exclusionary, causing damage to care in that it fails to take into account other important aspects of clinical knowledge and experience. Qualitative measures need to be utilized so that there is a richer amount of data which is presented to support not just EBPs, but also to support the flexibility that is so needed.

One positive aspect in the movement to EBP is that implementing shorter and more focused treatment plans is effective in quickly determining whether or not clients are receptive to assistance. There is less time spent on those clients who are not motivated and who are in different stages of change. By weeding these clients out, there is more time to work with those who are ready, thus eliminating some of the wait for service which occurs. It is a great deal easier to explain to a parent that their child is not ready to make changes and that treatment will be short as a result, than it is to tell them that they only get a certain number of sessions. When a few short sessions then occur, with little impact on the client, then the therapist becomes the one who is blamed. More training in motivation and stage of change would be very helpful in order to help the treating professional assess this, as well as be able to explain this to the client.

I believe that the funders dictating what needs to be used in order for agencies to receive funding is, in fact, morally reprehensible. Hall (2008) commended the core values of EBP in that they seek to determine the best approaches to be helpful to clients, which he viewed as being the core of ethical social work. The struggle he had as well was with linking specific clinical experiences with research design, which he found to be limiting. Hall(2008) questioned whether this would interfere with decisions being made in the best interest of the person. I believe that the stress and strain on front-line workers is difficult enough, without the need for staff to become researchers at the same time. I am all in support of demonstrating outcomes, and for indicating that what we are doing actually works. I believe that clients deserve the knowledge that they are entering into a partnership with more than just blind faith that they will be provided with some expertise on symptom relief and a push towards a “cure.” If however, practitioners are going to be expected to conduct research in addition to their already busy occupation, then training is needed to support them, there needs to be a modification of the other expectations of their role.

What most front-line workers seem to agree to is that despite whatever intervention is being implemented, it is the relationship which matters. The push for EBP has resulted in relationships being viewed as something which is no longer important nor valid. Relationships are being viewed as something which is not required when an EBP is delivered. In my research, I believe that this is an illusion, that relationships are not being regarded as diminished, but rather part and parcel of the administration of an EBP. Because of the focus on RCTs, and the scientific component of EBPs, relationships are not discussed the way they used to be, as when I referred to Carl Rogers (1958) and his viewpoint on warmth, unconditional positive regard and empathy. This does not mean that relationships do not and should not exist. I think that the lack of discussion of relationships is what results in professionals questioning the practicality of

implementing EBPs. Perhaps it is because providing treatment for mental health disorders used to be more of a “warm-fuzzy” kind of approach, and now it has moved to a focus on t-tests and data collection and entry which shifts treatment to being more scientifically-based/. Perhaps professionals and governments are so determined to prove outcomes that the real value of the therapeutic relationship has now become an oversight. Practitioners are caught up in proving that they provide a valuable commodity because they need employment. Unfortunately, the client often becomes lost in the system and they are engaged in something that is done to them, instead of something that is done with them.

I also still wonder if there is a quiet revolt which lies beneath the surface. A revolt, in which service providers are aware that they need to ‘play the game’ in order to satisfy the funders, yet continue to have faith in their innate abilities to help children out while ensuring that the process is client-driven and client-centred. Part of my research supports this however there has been just enough doubt cast to make me wonder. At least I know that I am not alone in my feelings and my experiences.

In this age of financial constraint, we as children’s mental health service providers will continue to be held accountable and will need to demonstrate efficacy and value for the dollar until there is some resistance which is taken seriously. I anticipate that resistance will arise from front-line staff when they become overwhelmed with data collection, overwhelmed with doing research themselves. Overwhelmed with having to justify the number of sessions required to help a family so that needs are addressed. Overwhelmed with perceiving that they offer a band aid approach and then need to send their clients home, only to be back on the waiting list a few short months later, for an even longer wait because their needs have intensified.

Families, parents in particular, will be a part of this resistance when they are finally exasperated with not getting what they need. Exasperated with having the needs of their children marginalized because of the hierarchy that exists which tells them that as a client, they are only allowed what professionals deem that they deserve, and that their opinions are not valid. I believe and I hope that we will move away from a stringent, ill-defined push for EBP and towards a more clearly defined yet less narrow viewpoint such as EIP. This will allow the expertise of the professional, as well as the valued opinion of the client, to be the team in the driver's seat. The team that will help determine will work for each individual, as opposed to having an intervention 'done' to the client based on a diagnosis.

Coincidental with the timing of writing this conclusion, I was asked by the agency I work for to attend a meeting regarding an application for a grant. I had heard that it was regarding EBPs but was unclear about what exactly we were meeting for. To my surprise, it was a meeting to discuss receiving a grant to help the children's mental health agencies move away from EBPs and move towards EIP. There is a great deal of work that goes into this application, and it will not likely happen for a few years however, it is interesting to know that the quiet revolution is starting to occur. This was not at a government level however, and funding may not change to support EIP as opposed to EBP but there is a discussion which is happening around it. Perhaps this time the movement will be less likened to an elephant in the room which is ignored, and more about the elephant being obvious, and more out in the open.

It is apparent to me that my colleagues feel the same way. When I first put my survey out, I was unsure of the kind of responses I was going to get with regards to EBP. While there are some front line workers who utilize manualized interventions all of the time, according to the survey, not all are of the belief that this is the best way of going about delivering service. I have

discovered that some professionals like the directionality which is provided, and feel more confident in implementing a manualized approach. Still others sit in the middle, liking the guidance which it provides however wanting the freedom of flexibility to adapt to the client's needs.

I understand the world of children's mental health very differently than I did prior to starting my work on a Master's degree. I understand that I needed to go through what I have been through in order to do what I want to do. I understand the difference in intensity and depth in the treatment of children with mental health disorders. I get it. I am very grateful for my experience and for deciding to pursue higher education, despite the fact that it has not been easy. I am again working for the manager whom I worked for when I was in the role of a therapist prior to returning to school, and I feel a different kind of respect, and I enjoy it. I feel like I have joined a group which was so elusive before and I feel like I have grown up. While I do not believe this is necessary or even desirable for others, it has been a private ambition which has meant a great deal to me personally.

I am not sure if I would have been an effective therapist without a Master's degree. I am not sure if I would feel that I am effective without the experience that I have had. I am still not sure if I would be an effective therapist without incorporating EBP into my work. I do know that I feel probably about as effective as I will ever feel now, given that I have all of those as part of my portfolio. I do think that as mental health professionals, we all need to do what we can to be enough so that we might be able to make a difference.

References

- Adams, K. B., Matto, H. C. & Winston L. (2009). Limitations of evidence-based practice for social work education: Unpacking the complexity. *Journal of Social Work Education*, 45(2), 165-186.
- Albano, A. M., & Kendall, P. C. (2002). Cognitive behavioural therapy for children and adolescents with anxiety disorders: Clinical research advances. *International Review of Psychiatry*, 14, 129-134.
- Akobeng, A. K. (2005). Understanding randomised controlled trials). *Archives of Disease in Childhood*, 90, 840-844.
- American Psychological Association (2008). American Psychological Association Task Force on Evidence-Based Practice for Children and Adolescents. *Disseminating evidence-based practice for children and adolescents: A systems approach to enhancing care*. Retrieved from <http://www.apa.org/practice/resources/evidence/children-report.pdf>
- American Psychological Association (2010). *Concise Rules of APA Style*. Baltimore, MD: United Book Press.
- American Psychological Association (1980). *DSM-III-R: Diagnostic and Statistical Manual of Mental Disorders* (3rd edition), Text Revision. Arlington, VA: American Psychiatric Publishing Inc.
- American Psychological Association (2000). *DSM-IV-TR: Diagnostic and Statistical Manual of Mental Disorders* (4th edition), Text Revision. Arlington, VA: American Psychiatric Publishing Inc.
- Angold, A., Costello, E.J., & Erkanli, A. (1999) Comorbidity. *Journal of Child Psychology and Psychiatry*, 40, 57-87.

- Armstrong, A. (2008) Beyond Resistance: a Response to Žižek's Critique of Foucault's Subject of Freedom. *Parrhesia Journal*, 5, 19-31. Retrieved from http://www.parrhesiajournal.org/parrhesia05/parrhesia05_armstrong.pdf.
- Barker, R. L. (Ed.). (2003). *The social work dictionary* (5th edition). Washington, DC: NASW.
- Barwick, M. A., Boydell, K. M., Stasiulis, E., Ferguson, H. B., Blase, K., & Fixsen, D. (2005). *Knowledge Transfer and Implementation of Evidence-based Practice in Children's Mental Health*. Toronto: Children's Mental Health Ontario. Retrieved from www.kidsmentalhealth.ca
- Bandura, A. (2001). Social cognitive theory: An agentic perspective. *Annual Review of Psychology*, 52, 1-26.
- Bayer, R. & Spitzer, R.L. (1985). Neurosis, psychodynamics, and DSM-III-A history of the controversy. *Archives of General Psychiatry*. 42(2), 187-196.
- Beck, A. T., Rush, A. J., Shaw, B.F., Emery, G. (1979). *Cognitive Therapy of Depression*. NY, NY: Guilford Press.
- Beddoe, L. (2010). Investing in the future: Social workers talk about research. *British Journal of Social Work*, 41(3), 1- 19.
- Berg, I. K. (1994). Family-based services: A solution-focused approach. *British Journal of Social Work*. 41(3), 557-575.
- Berger, R. (2010). EBP Practitioners in search of evidence. *Journal of Social Work*, 10(2), 175-191.
- Blom, B. (2009). Knowing or un-knowing? That is the question in the era of evidence-based social work practice. *Journal of Social Work*. 9, 158-177.
- Calhoun, M. (2002, 2003). *Grant results report: Evidence-based care for persons*

- with serious mental illness*. Retrieved June 24, 2003, from <http://www.rwjf.org/reports/grr/036805.htm>.
- Cartwright, N. (2007). Are RCTs the gold standard? *Biological Societies*, 2, 11-20.
- Cochrane, A. L. (1972). *Effectiveness and efficiency: Random reflections on health services*. Cambridge, UK: Cambridge University Press.
- Clegg, S. (2005). Evidence-based practice in educational research: a critical realist critique of systematic review. *British Journal of Sociology of Education*, 26(3), 415–428.
- Deleuze, G. & Guattari, F. (2000). *Anti-Oedipus: Capitalism and schizophrenia*. (R. Hurley, M. Seem, & H. R. Lane, Trans.). Minneapolis: University of Minnesota Press. (Original work published, 1972).
- Devisch, I. & Murray, S.J. (2009). ‘We hold these truths to be self-evident’: deconstructing ‘evidence-based’ medical practice. *Journal of Evaluation in Clinical Practice*, 15(6), 950–954.
- Drake, R.E., Goldman, H.H., Leff, H., Lehman, A.F., Dixon, L., Mueser, K.T., & Torrey, W.C. (2001). Implementing Evidence-Based Practices in Routine Mental Health Service Settings. *Psychiatric Services*. 52(2), 179- 182.
- Duncan, M. (2004). Autoethnography: Critical appreciation of an emerging art. *International Journal of Qualitative Methods*, 3(4), 28-39.
- Ellis, C. (1991). Sociological introspection and emotional experience. *Symbolic Interaction*, 14(1) 23-50.
- Ellis, C.S. & Bochner, A.P. (2006) Analyzing analytic autoethnography: An autopsy. *Journal of Contemporary Ethnography*, 35(4), 429-449.
- Evans, D. Hierarchy of evidence: a framework for ranking evidence evaluating healthcare

- interventions. *Journal of Clinical Nursing*, 12, 77–84.
- Ferguson, H. (2003). Outline of a critical best practice perspective on social work and social care. *British Journal of Social Work*. 33, 1005–24.
- Foucault, M. (1970). *The order of things: archaeology of the human sciences*. NY, NY: Vintage.
- Foucault, M. (1975). *Discipline and Punish: The Birth of the Prison*. (A. Sheridan, Trans. 1977). Harmondsworth, U.K.: Peregrine.
- Foucault, M. (1976). *The History of Sexuality Volume I*. (R.Hurley, Trans. 1978). NY, USA: Pantheon Books.
- Foucault, M. (1977). *Discipline and punish*. London, U.K: Penguin.
- Foucault, M. (1980). *Power/knowledge: Selected interviews and other writings, 1972-1977*. C. Gordon (Ed.). NY, NY: Pantheon Books.
- Foucault M. (1984). On the genealogy of ethics: An overview of work in progress. In P. Rabinow, (Ed.), *The Foucault Reader*, (pp. 340–72). London, U.K: Penguin Books.
- Foucault M. (1991). *Governmentality*. In G. Burchell, C. Gordon, & P. Miller (Eds.) *The Foucault effect: Studies in governmentality*, (pp. 87–104). Hemel Hempstead, U.K.: Harvester Wheatsheaf.
- Foucault, M. (1998). *The History of Sexuality: The Will to Knowledge*, London: Penguin.
- Fox, N. (1995). Postmodern perspectives on care: The vigil and the gift. *Critical Social Policy*, 15(44-45), 107-125.
- Freshwater, D. & Rolfe, G. (2004). *Deconstructing evidence-based practice*. NY, NY: Routledge.

- Gambrill, E. (2001). Social work: An authority-based profession. *Research on Social Work Practice*. 11(1), 166–75.
- Gambrill, E. (2006). Evidence-based practice and policy: Choices ahead. *Research on Social Work Practice*, 16(3), 338-357.
- Garrett, P.M. (2005). Social work’s “electronic turn”: Notes on the deployment of information and communication technologies in social work with children and families. *Critical Social Policy* 25(4), 529–53.
- Gardner, R. A. (1973). The talking, feeling and doing game: A psychotherapeutic game for children. Creskill, NJ: Creative Therapeutics.
- Gibbs, L. & Gambrill, E. (2002). Evidence-based practice: Counterarguments to objections. *Research on Social Work Practice*, 12(3), 452–476.
- Gilbert, T. & Powell, J. L. (2009). Power and social work in the United Kingdom: A Foucauldian excursion. *Journal of Social Work*, 10(1), 3-22.
- Gilgun, J. F. (2005). The four cornerstones of evidence-based practice in social work. *Research on Social Work Practice*. 15(1), 52-61.
- Griffiths, P. (2005). Evidence-based practice: A deconstruction and postmodern critique: book review article. *International Journal of Nursing Studies*, 42(3), 355-361.
- Grossman, J. & Mackenzie, F. J. (2005). The randomized controlled trial: gold standard, or merely standard? *Perspectives in Biological Medicine*, 48(4) 516-534.
- Gray, M., & McDonald, C. (2006). Pursing good practice? The limits of evidence-based practice. *Journal of Social Work*. 6(1) 7-20.
- Gutting, G. (1989). *Michel Foucault’s Archeology of Scientific Reason*. U.K.: Cambridge University Press.

- Hall, J. C. (2008). A practitioner's application and deconstruction of evidence-based practice. *Families in Society: The Journal of Contemporary Social Services*, 89(3), 385-393.
- Heaton, J. (1999). The gaze and the viability of the carer: A Foucauldian analysis of the discourse of informal care. *Sociology of Health and Illness*. 21(6), 759–77.
- Howard, M., McMillen, C. & Pollio, D. (2003) Teaching evidence-based practice: Toward a new paradigm for social work education. *Research on Social Work Practice*. 13(2), 234-259.
- Hoagwood, K., Burns, B. J., Kiser, L., Ringeisen, H., & Schoenwald, S. K. (2001). Evidence-based practice in child and adolescent mental health services. *Psychiatric Services*, 52(9), 1179- 1189.
- Holmes, D., Murray, S. J., Perron, A. & Rail, G. (2006). Deconstructing the evidence-based discourse in health sciences: truth, power and fascism. *International Journal of Evidence Based Healthcare*, 4, 180-186.
- Hranov, L.G. (2007). Comorbid anxiety and depression: illumination of a controversy. *International Journal of Psychiatry in Clinical Practice*. 11 (3), 171-189.
- Humphries B. (2003). What else counts as evidence in evidence-based social work? *Social Work Education: The International Journal*. 22(1), 81-91.
- International Federation of Social Workers, (2000). Definition of social work. Retrieved December 2008 from <http://www.ifsw.org/en/f38000138.html>.
- Iowa PIC Project, (2003). *Evidence-Based Practices: An Implementation Guide for Community-Based Substance Abuse Treatment Agencies*. Retrieved from [www.uiowa.edu/~iowapic/files/EBP Guide - Revised 5-03.pdf](http://www.uiowa.edu/~iowapic/files/EBP%20Guide%20-%20Revised%205-03.pdf)

- Kaptchuk, T.J. (2001). The double-blind, randomized, placebo-controlled trial: gold standard or golden calf? *Journal of Clinical Epidemiology*, 54(6), 541-549.
- Kazdin A. E. (1999). Current (lack of) status of theory in child and adolescent psychotherapy research. *Journal of Clinical Child Psychology*, 28, 533-543.
- Keenan, E.K. (2001). Using Foucault's "disciplinary power" and "resistance" in cross-cultural psychotherapy, *Clinical Social Work Journal*, 29(3), 211-26.
- Kendall, P.C. & Clarkin, J.F. (1992) Introduction to Special Section: Comorbidity and Treatment Implications. *Journal of Consulting and Clinical Psychology*, 60(6), 833-834.
- Kendall, P. C. & Hedtke, K. A. (2006). Coping cat workbook. *Child Therapy Workbooks Series* (2nd ed.). Ardmore, PA: Workbook Publishing.
- Kessler, R. C. (1994). The National Comorbidity Survey of the United States. *International Review of Psychiatry*, 6(4), 365-376.
- Koegl, C. J., Augimeri, L. K., Ferrante, P., Walsh, M., & Slater, N. (2008). A Canadian programme for child delinquents. In R. Loeber, N. W. Slot, P. van der Laan, and M. Hoeve, (Eds.), *Tomorrow's criminals: The development of child delinquency and effective interventions*, (pp. 285 - 300). Aldershot, U.K.: Ashgate.
- Korine, H., Clark, L. & Lewis, J. (Producer) & Clark, L. (Director). (1995). Kids [Motion Picture]. U.S.: Guys Upstairs.
- Krueger, R. F. & Markon, K. E. (2006). Reinterpreting Comorbidity: A Model-Based Approach to Understanding and Classifying Psychopathology. *Annual Review of Clinical Psychology*, 2, 111-133.
- Larner, G. (2004). Family Therapy and the Politics of Evidence. *Journal of Family Therapy*, 26(1), 17-39.

- Lather, P. (2004). This *IS* your father's paradigm: Government intrusion and the case of qualitative research in education. *Qualitative Inquiry*, 10(1), 15-34.
- Lunt N., Shaw I., Mitchell F. (2009). Practitioner Research in Children 1st: Cohorts, Networks and Systems: Report Prepared for The Institute for Research and Innovation in the Social Services 2009. Retrieved from <http://www.iriss.org.uk/sites/default/files/iriss-practitioner-research-children1st-report-2009.pdf>
- MacPhee and Pratt, P. (2005). Evidence-based practice. *Journal of Pediatric Nursing*, 20(5), 396-8.
- Mantzoukas, S. (2008). A review of evidence-based practice, nursing research and reflection: Levelling the hierarchy. *Journal of Clinical Nursing*, 17, 214–223.
- Mason, M.K. (2012). Foucault and his Panopticon. Retrieved from <http://www.moyak.com/papers/michel-foucault-power.html>
- McIlveen, P. (2008). Auto ethnography as a method for reflexive research and practice invocational psychology. *Australian Journal of Career Development*. 17(2), 13-20.
- Mills, E. J., Montori, V. M., & Guyatt, G. H. (2004). Evidence based clinical-practice. *Brief Treatment and Crisis Intervention*. 4(2), 187–194.
- Mor Barak, M., Nissly, J.A. and Levin, A. (2001). Antecedents to retention and turnover child welfare, social work and other human service employees: What can we learn from past research? A review and metanalysis. *Social Service Review*, 75, 625–61.
- Patterson, J. E., Miller, R. B., Carnes, S. and Wilson, S. (2004). Evidence-based practice for marriage and family therapy. *Journal of Marital and Family Therapy*, 30, 183–95.
- Phelan, T. (2004). 1-2-3 Magic – Effective Discipline for Children 2-12. Chicago, Illinois: ParentMagic, Inc.

- Pollio, D. E. (2006). The Art of Evidence-Based Practice. *Research on Social Work Practice*, 16(2), 224-232.
- Porter, S. & O'Halloran, P. (2009). The postmodernist war on evidence-based practice. *International Journal of Nursing Studies*, 46(5), 740-748.
- Prevention of Violence in the Workplace Training Canadian Association of Provincial Safety Councils. Retrieved from <http://www.provincialcouncils.ca>.
- Reed-Danahay, D. E. (1997). *Auto/Ethnography: Rewriting the self and the social*. Oxford, UK: Berg.
- Reid, W. J., Kenaley, B. D., & Colvin, J. (2004). Do some interventions work better than others? A review of comparative social work experiments. *Social Work Research*, 28(2), 71-81.
- Rogers, C. R. (1958). The Characteristics of a helping relationship. *Personnel and Guidance Journal*, 37(1), 6-16.
- Rycroft-Malone, J., & Stetler, C. B. (2004). Commentary on evidence, research, knowledge: A call for conceptual clarity: Shannon Scott-Findlay & Carolee Pollock. *Worldviews on Evidence-Based Nursing*, 1(2), 98-101.
- Sackett, D. L., Rosenberg, W. M. C., Gray, J. A. M., Haynes, R.B. & Richardson, W.S. (1996). Evidence based medicine: What it is and what it isn't. *British Medical Journal*, 312(7023), 71-72.
- Sackett, D. L. (1997) Evidence-based medicine. *Seminars in Perinatology*, 21(1), 3-5.
- Sackett, D. L., Richardson, W. S., Rosenberg, W. & Haynes, R. B. (1997). *Evidence-based medicine: How to practice and teach EBM*. NY, NY: Churchill Livingstone.

- Scheyett, A. (2006). Silence and Surveillance: Mental Illness, Evidence-Based Practice, and a Foucaultian Lens. *Journal of Progressive Human Services, 17*(1), 71-92.
- Shapiro, S.P. (2005). Agency Theory. *Annual Review of Sociology, 31*, 264-284.
- Sheldon, B. (1995) *Cognitive-Behavioural Therapy: research and practice in health and social care*. NY, NY: Routledge Publishers.
- Shellenberger, S. & Hoffman, S. (1995). The changing family–work system. In R. H. Mikesell, D. Lusteran, & S. H. McDaniel, (Eds.). *Integrating family therapy: Handbook of family psychology and systems theory*. Washington, DC, US: American Psychological Association.
- Simon, S. D. (2001). Is the randomized clinical trial the gold standard of research? *Journal of Andrology, 22*(6), 938-943.
- Sparkes, A. C. (2000). Autoethnography and narratives of self: Reflections on criteria in action. *Sociology of Sport Journal, 17*, 21-43.
- State of Oregon (2003) “An Act: SB 267, Chapter 669 Oregon Laws.” Retrieved from www.leg.state.or.us/orlaws/sess0600.dir/0669ses.htm (15 November 2004); and Oregon Office of Mental Health and Addiction Services, “Proposed Operational Definition for Evidence-Based Practices, Final Draft,” 1 June 2004, www.dhs.state.or.us/mentalhealth/ebp/definition0722.pdf (10 November 2004).
- Sturat, R. B. and Lilienfeld, S. O. (2007). The evidence missing from evidence-based practice. *American Psychologist, 62*, 615–16.
- Thyer, B. A., & Myers, L. L. (2010). The quest for evidence-based practice: A view from the United States. *Journal of Social Work, 11*(1), 8-25.
- Tomasulo, D. (1999). Group therapy for people with mental retardation: The interactive-

- behavioral model. In D. Wiener (Ed.), *Beyond talk therapy: Using movement and expressive techniques in clinical practice* (pp. 145–164). Washington, DC: American Psychological Association.
- Trevithick, P. (2008). Revisiting the knowledge base of social work: A framework for practice. *British Journal of Social Work*, 38, 1212–37.
- Unison Health and Community Services, (2010). Evidence-Informed Practice Workbook. Retrieved from http://unisonhcs.org/fileadmin/doc/EIP/EIP_Workbook_-_last_revised_Apr_2012.pdf
- Van de Luitgaarden G. M. J. (2009). Evidence-Based Practice in social work: Lessons from judgment and decision-making theory. *British Journal of Social Work*. 39(2), 243-60.
- Waddell, C. & Godderis, R. (2005). Rethinking Evidence-Based Practice for children’s mental health. *Evidence Based Mental Health*, 8, 60-62.
- Waddell, C., Godderis, R., Wond, W., Garland, O. (2005). Implementing evidence-based practice in children’s mental health. *Children’s Mental Health Policy Research Program*, 1(6). Retrieved from http://www.childhealthpolicy.sfu.ca/research_reports_08/rr_pdf/RR-12-05-full-report.pdf.
- Wall, S. (2006). An Autoethnography on learning about Autoethnography. *International Journal of Qualitative Methods*, 5(2), 1-12.
- Webb S. A. (2001). Some considerations on the validity of Evidence-Based Practice in social work. *British Journal of Social Work*. 31(1), 57-79.
- Webster (2012). Retrieved from <http://www.websters-dictionary-online.org/definitions/evidence>.

- Webster-Stratton, C., (2001). The incredible years: Parents, teachers, and children training series. In S.I. Pfeiffer & L.A. Reddy (Eds.). *Innovative mental health interventions for children: Programs that work*. NY, NY: Haworth Press.
- Westen, D., Novotny, C.M., & Thompson-Brenner, H. (2004). The Empirical Status of Empirically Supported Psychotherapies: Assumptions, Findings, and Reporting in Controlled Clinical Trials. *Psychological Bulletin*, 130(4), 631-663.
- Whitehouse, E. & Pudney, W. (1997). A Volcano in my tummy: Helping children to handle anger: A resource book for parents, caregivers and teachers. B.C., Canada: New Society Publishers.
- Winch, S., Creedy, D. & Chaboyer, W. (2002). Governing nursing conduct: the rise of evidence-based practice. *Nursing Inquiry*, 9(3), 156–161.
- Ontario College of Social Workers and Social Service Workers.
Retrieved from www.ocswssw.org.
- Yunong, H. & Fengzhi, M. (2009). A Reflection on reasons, preconditions, and effects of implementing evidence-based practice in social work. *Social Work*, 54, 177–81.
- Zlotnik, J. L. (2007). Evidence-based practice and social work education: A view from Washington. *Research on Social Work Practice*, 17, 625–9.

Appendix A

Confidential Survey

Deconstructing Evidence-Based Practice and its Application to Children with Co-Morbid Mental Health Disorders

1. Please provide your working definition of Evidence-Based Practice (EBP) (don't look it up – in your own words please).

2. Please provide your working definition of Evidence-Based Treatment (EBT) (don't look it up – in your own words please).

3. Please provide your working definition of Evidence-Informed Practice (EIP) (don't look it up – in your own words please).

4. How much did you learn about EBP with regards to children's mental health, when you completed your formal education?

1.....	2.....	3.....	4.....	5.....	6.....	7.....	8.....	9.....	10
There was no mention of EBP	We discussed it occasionally		We focussed on EBP about half of the time in class			We spent a great deal of time on EBP		We discussed it extensively	

5. On a scale of 1 to 18, how equipped do you feel you are to use EBP in your work with clients?

1.....	2.....	3.....	4.....	5.....	6.....	7.....	8.....	9.....	10
Very little- I am not very familiar with EBPs	I can get by		Somewhat			I am pretty equipped to use EBPs		I use EBPs all the time in my work with clients	

6. On a scale of 1 to 10, how much do you feel EBP contributes to the effectiveness of your work?

1.....	2.....	3.....	4.....	5.....	6.....	7.....	8.....	9.....	10
A great deal – it is very helpful	Pretty effective- provides some framework for treatment		Somewhat effective for clients			I don't find EBPs helpful		Not at all- in fact it is detrimental	

7. What are your reasons for feeling that way?

8. How confident are you in your understanding of EBP?

1.....	2.....	3.....	4.....	5.....	6.....	7.....	8.....	9.....	10
Not very confident at all	A little confident		Somewhat confident			Pretty confident - I speak about it regularly with my colleagues		Very confident	

9. Do you feel that you need more training in EBP?

1.....	2.....	3.....	4.....	5.....	6.....	7.....	8.....	9.....	10
Need a lot more training		More training would be very helpful		Need some training		Could use a little more training			No further training needed

10. If you feel that you need more training, what sort of training might be helpful?

11. On a scale of 1 to 10, how likely are you to ask peers for more information on EBP?

1.....	2.....	3.....	4.....	5.....	6.....	7.....	8.....	9.....	10
Not likely		I might listen if others are talking about it		Somewhat likely		I will some- times ask my colleagues for more			Very likely- I do it all the time

12. On a scale of 1 to 10, how likely are you to ask a manager for more information on EBP?

1.....	2.....	3.....	4.....	5.....	6.....	7.....	8.....	9.....	10
Never		I will if it is brought up to me and I need more information		Somewhat likely - we discuss EBPs in supervision		I will often seek out my manager for information			Very likely - I have many times in the past

13. Would you say you are nervous to ask for more information on EBP because you think you *should* know what it is?

1.....	2.....	3.....	4.....	5.....	6.....	7.....	8.....	9.....	10
Not at all- I feel there is more that I need to know				Somewhat nervous- it seems like everyone else knows more about it than I do					Very nervous- I don't want to look incompetent

14. Do you worry that you will be “caught” not using EBP because you aren’t exactly sure what it is?

1.....	2.....	3.....	4.....	5.....	6.....	7.....	8.....	9.....	10
All the time – I don’t really think I use EBPs in practice	If my manager knew, I think I would be in a lot of trouble	Sometimes - I am not always sure I’m using EBPs properly					I feel like I am familiar with EBPs and use them enough to ensure I am doing what is expected of me	Not at all - I use EBPs extensively	

15. Have you ever written an Evidence Based Treatment (EBT) intervention into your treatment plan and then found that you didn’t actually use it?

1.....	2.....	3.....	4.....	5.....	6.....	7.....	8.....	9.....	10
All the time	Yes, I don’t really find they are that beneficial	Sometimes- sometimes things change in the course of treatment					Very rarely- EBPs are packaged nicely so that the treatment plan is nicely laid out	Never-I always follow the treatment plan as it is laid out	

16. Have you ever written an Evidence Based Treatment (EBT) into your treatment plan without actually intending to use it because you did not think it would be beneficial, but you felt you needed to write something supporting this anyway?

1.....	2.....	3.....	4.....	5.....	6.....	7.....	8.....	9.....	10
Often- they are useless but it is what the government wants to see	I frequently include them in treatment plans just so they “look good”	Sometimes- EBTs don’t always provide perfect “fit” for the client					I use manualized plans for most of my clients	Never- I always use EBPs	

17. Do you think that clients who are experiencing co-morbid mental health symptoms can be effectively treated using EBP interventions?

18. Can you share your thoughts behind your answer?

19. To what extent do you agree with the shift to EBP in social services?

1.....	2.....	3.....	4.....	5.....	6.....	7.....	8.....	9.....	10
Not at all- the people that make these changes do not understand frontline work	I don't really agree but that is the way the funders will give us money so we have to abide by it			Some - we all have to show we are accountable			EBP is a better way of doing business than what we were doing 10 years or more ago		A great deal -it is how we are funded and EBPs are practical and show that treatment works

20. Approximately how long you been working at this agency (including relief and part-time?

- ☐ Less than 2 years
- ☐ Less than 5 years
- ☐ 5 to 10 years
- ☐ 10 to 15 years
- ☐ 15 years or more

Thank you so much for taking the time to complete this survey and for offering your very valuable experiences and opinions. When I have completed my thesis, I will be writing a report to share with all the staff and management.

Sue Etherington